

Basal Exposure Therapy

BET

The BET Model's Theoretical foundation – Part 1

Cybernetics

as a basis for understanding and intervention

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1. Introduction

Basal Exposure Therapy (BET) is a treatment that has been developed and applied at a speciality unit (Special Section B) at Vestre Viken Hospital Trust since the year 2000. BET is used primarily with patients who are deemed resistant to other treatment attempts and aims at stabilization and functional improvement. This pamphlet is the first part of a three-part theory manual, and presents the main foundation of the BET model - cybernetic theory. Part 2 and 3 accounts for the use of developmental psychology and existential perspectives in BET. These perspectives are also referred to in Part 1, considered within the overall cybernetic framework.

BET is used primarily where other treatments have had no effect

BET is theoretically anchored in cybernetics, developmental psychology and existential philosophy

Common characteristics of patients prioritised to BET are severe generalised, psychological and psychosocial dysfunction reflected in GAF scores below 30 (APA, 2000). Deviant and dysfunctional behaviours including self-harm and suicide attempts are common features of the clinical picture. One also sees symptoms such as delusions, hallucinations and disorientation, which can be present or vary in intensity depending on the degree of subjectively experienced stress. Within the perspective of BET, these patients are seen to experience various forms of existential catastrophes eliciting anxiety towards disintegration such as the fear of dissolving, falling to pieces, or suffering eternal pain or emptiness (Heggdal, 2008; 2010).

Patients prioritised to BET show dramatically varying or consistently low level of functioning

BET patients all experience an intrusive feeling of catastrophic existential anxiety

These patients, who experience a high symptom load and suffer severely, are termed marginalised patients within the BET model. Marginalised patients spend long periods, often several years in emergency wards and wards for treatment of psychotic conditions. Individuals are also transferred to secure departments if they directly or indirectly endanger the lives or health of others, or simply because that's where they can receive the level of behavioural regulation necessary to ensure protection against themselves. Supportive and stabilising in-patient treatment, which for this group usually includes a spectrum of medical interventions, has in the best case only an initial and transient effect on the patient's ability for functional self-regulation. The ineffectiveness of treatment for this patient group has meant that in-patient treatment is recommended only for limited use in connection with short-term crisis stays. This practice has been backed up by the theoretical assumption that the patients risk pathological dependency and increased behavioural disturbances with long-term admissions (e.g. Nurnberg & Suh, 1978; Rosenbluth & Silver, 1992; Norwegian Directorate of Health, 2008).

Marginalised patients occupy many in-patient beds in mental health care systems

Because of the lack of effective methods, treatment is most often based on psycho-pharmacological attempts to moderate symptoms and stabilise the patient

A prevailing understanding and attitude is that long-term admission can be bad for marginalised patients

The use of short-term crisis stays for these patients is challenging owing to several complex conditions. A GAF score \leq 30 indicates that the person is at risk for committing suicide or serious injury to himself or to others. This makes long-term

Frequent or persistent risk to life or health makes it difficult to limit hospital stays

hospital admissions necessary in many cases. Furthermore vulnerable individuals can experience the health service's attempts to limit hospital stays as rejection, denial of responsibility and gross negligence, which can lead to re-traumatisation and further dysfunction (Bateman & Fonagy, 1999; Balint, 1968). In encountering these patients, the treatment apparatus is constantly in a situation where it cannot do right for doing wrong. On the one hand, there is the risk of creating pathological dependency. On the other, lack of treatment may cause the patient to become increasingly resigned and/ or aggressive as a result of the experience of being deserted and abandoned. The consequence in both cases can be a further reduction in functioning with the cementation of pathological patterns over time. Many also become demoralised by encountering different and inconsistent attitudes by the professionals within the health care system.

For many marginalised patients early discharge can reactivate and reinforce relational trauma

Encountering marginalised patients places the health services in a "double-bind" situation

Marginalised patients get bounced between departments and treatment levels

How can one proceed then with implementing function-improving processes for supposedly treatment-resistant, marginalised patients? According to Yalom (2002) the patient has to take responsibility for both the problem and the solution if treatment is to be effective. It does not help that the problem is explained in ways that deprive the patient of authority as the agent of change. Deprivation of authority can result when the cause to the problem is attributed to genetic or neuro-biological conditions, or the traumatized patient is cast in the role of victim. This pamphlet describes how BET takes its starting point in cybernetic theory to help patients take responsibility for creating movement in locked-in conditions. In BET, the patient's existential catastrophic anxiety is punctuated (is explained) as a phobic state created and maintained through the patient's avoidance behaviour: "You have problems because you avoid – the solution is to stop avoiding" (Heggdal, 2008; 2010). To stop avoiding in this context will mean that the patient chooses to expose herself to affective arousal that is experienced as possibly leading to existential catastrophe. Phobic behaviour is irrational and so too is existential catastrophic anxiety. Exposure therapy for low-functioning patients is conditional therefore on thorough preparation, adaptation and consolidating measures to ensure lasting treatment effects.

For the treatment to be effective, patients must take responsibility for both the problem and the solution

In BET, the problem is explained in such a way that all responsibility is allocated to the patient

Existential catastrophe anxiety is a phobic condition that can be treated by exposure

Much of the course of treatment is about preparation for exposure and consolidation of the ability to self-expose

The BET process proceeds through five phases (see Heggdal 2008 and 2010 for more specific descriptions):

- 1) Establishment of secure relations between the patient and the therapist / treatment environment ("secure base")
- 2) Investigation of the existential catastrophe anxiety, clearing of therapeutic goals and division of tasks (working alliance)
- 3) Investigation of avoidance behaviours and identification of conscious and less conscious avoidance patterns
- 4) Exposure to expectations about and experiences of existential catastrophe (desensitisation and flooding)
- 5) Solution-focused consolidation of the ability to self-expose

BET is built around well known therapeutic elements such as empathy, responsibility, raising consciousness of the effect of avoidance behaviour, exposure and empowerment

Described below is how the phobia perspective and cybernetic theory can produce an appropriate framework for treating this patient group. First central themes in cybernetics and systems theory are presented. This is then used to illuminate general components of the BET model and components connected to specific phases in the treatment course.

This pamphlet describes how BET uses cybernetic theory to explain marginalised patients' conditions and complete function-improving treatment

2. Cybernetics

Cybernetics relates to regulatory mechanisms in systems (Bateson, 1972, 1985). General systems theory also is part of the cybernetics paradigm. Systems theory is an open model that can be applied to describe all “mental” and physical/ material phenomena. Everything from a collection of particles to galaxies is viewed as systems. A system consists of subsystems, and the system itself is a subsystem of larger systems, often called macro-systems or supra-systems. While system theory says that the reality within and around us is a web of interconnected totality of systems, cybernetics tells us how the interaction between systems within this totality occurs. What entity of this totality that we see as representing “the system” depends on the position we choose to take with regards to the observed phenomenon. The central point is that everything around us is interconnected, can be seen from different angles and levels and is influenced directly and/ or indirectly through a multitude of cause and effect mechanisms.

A system consists of subsystems and is itself a subsystem of larger systems

The chosen standpoint of the observer determines which systems and mechanism that are focused upon

A self-regulating system is also called an *eco-mental system*, owing to the fact that it has or is a “self-regulating mind” (Ølgaard, 2004). This may seem obvious when it comes to people and other living beings. “Mind”, as the concept is applied in cybernetics, means that all self-regulating systems are regulated by mental processes, as with the global eco-system, relations between a dog and its owner and life in an anthill. To have a “mind” is seen in cybernetics as a characteristic of all self-regulating systems of a certain complexity (Bateson, 1972, 1985). The system's inherent “mind” is the system's thermostat so to speak, signifying it as the very mechanism that defines the system as self-regulating.

All self-regulating systems are governed by mental processes

The system's “mind” is a thermostat that regulates the system

The self-regulating system's thermostat is comprised of circular chains of cause/ effect sequences that react to “differences” or “deviations”. Identification of deviations provides information about the state of the system and leads to feedback that adjusts the system. The system is self-regulating in the sense that it seeks out *dynamic equilibrium*, which means it is in a changing state of imbalance around a given balance point. Regulation around the balance point occurs through feedback to the system's thermostat via different feedback mechanisms. *Positive feedback* is used most often about “confirming feedback” (= “on” or “continue”), while *negative feedback* means “corrective feedback” (= “off” or “brake”). “Positive” and “negative” in this context are value-neutral concepts and must not be understood semantically as meaning “good” or “bad”. Besides regulation by feedback, which serves to maintain equilibrium consistent with the set value of the system's thermostat, circumstances could make it necessary to calibrate the thermostat; that is, change the “balance point” itself. (Read more about this in paragraph 8, Specification of the rationales for the BET model).

Self-regulating systems identify deviations and initiate adjusting feedback processes

**Positive feedback says
Continue**

**Negative feedback says
Stop**

A system is regulated by feedback mechanisms and/ or upon calibration of the system's thermostat

3. A system's flexibility and adaptational ability

A self-regulating system will at any given time be in movement around a balance point trying to maintain dynamic equilibrium (homeostasis). Maintenance of equilibrium requires adaptation to both ("own") subsystems and to larger systems which the system is part of. An attempt to maintain equilibrium can also involve the system "taking over" or "absorbing" imbalance (failing self-regulation) in their "own subsystems" or from other "higher" system levels.

The systems are unstoppable in a dynamic exchange between "requiring" and "being required" to adapt

A system's inner state decides its flexibility (tolerance for imbalance), ability to adapt and simultaneously maintain its existence. In cybernetics, the system's inner state is characterised by the concept of entropy, which means "degree of disorder" (Bateson, 1975). A system characterised by inner disorder ("high" entropy) might in interaction with other systems appear as to be flexible and have high adaptational ability. This "loosely organised" system will, however, easily be destabilised, and its attempt at adaptation could involve such large deviations from the system's functional point of equilibrium that it passes into a chaotic state. An inner state characterised by a high degree of order (negentropy), on the other hand will make the system rigid with lacking flexibility in interaction with other systems. When subjected to a long-term strain (the demand for adaptation) the "rigid" system can undergo a sudden and dramatic destabilisation process when it must finally give in to overload. Cybernetics tells us that both inner disorder ("looseness") and inner order ("rigidity") can weaken the system's adaptational ability, undermining functional self-regulation and threatening the system's existence.

A system's ability to adapt to inner and outer changes depends on the system's flexibility

Optimal flexibility is found in the span between rigidity and chaos and depends on factors such as stress and time

When a system is destabilised or disorganized, the compensating and organizing (that is, the necessary, regulatory) activity is taken care of by one or several macro-systems, of which the system is a subsystem. For a "loosely organized system" the embracing, regulating macro-system has an organizational function, while for a "rigidly organized" system, the macro-system will compensate for the lack in flexibility. The development of flexibility and the ability to adapt in both a chaotic and a rigid system will require that the macro-system winds down its regulatory and compensatory activity. The chaotic (sub) system must be challenged with respect to organisation while the rigid (sub) system must be challenged through destabilisation.

A system's deficient adaptational ability is compensated for at a higher system level

Re-establishing the ability to self-regulation in chaotic or rigid systems requires that the macro-system winds down the compensatory, regulatory activity

4. Dynamic equilibrium and change

While self-regulatory systems seek out equilibrium, all systems are in continuous change. Change can happen gradually, for example in ageing, or with the replacement of individual system components, without threatening the system's dynamic equilibrium. Changes can however, happen so suddenly, or over time involve such major strains on a system, that a great deal of energy is required to maintain equilibrium. If the strain exceeds the system's capacity and actual adaptional ability, a "crisis" arises that forces re-adjustment in order to preserve the system's existence. Painful re-adjustments will often be a natural and necessary part of a system's "life". A growing crab, for example, must step out of its shell and for some time become more vulnerable while it develops a bigger shell; government crises are naturally occurring and are part of functional self-regulation in our highly stable political system; and a young person controlled by over-protective parents must destabilize the family in order to be able to establish himself as autonomous and self-regulating.

From a cybernetics perspective, patients in the psychiatric health services can be seen as having been subject to "demands" from the internal and external environments that exceed the system's (patient's) capacity and adaptional ability. The destabilised system's equilibrium must then be taken care of on, or from, a "higher" system level. In order for the de-stabilized system to re-establish self-regulation, its adaptational ability must be reinforced and/ or its re-adjustment ability developed. Self-regulation again can be achieved by increasing "endurance", that is, reinforcing the ability to practice self-regulatory activity over time. This is however a solution that can exceed the system's conditions and capacity. Alternatively, one can identify inner/ outer strains, in order to implement measures to remove these, or moderate the destabilizing effect they have on the system. A final possibility is to change the system's "settings" or "set values" for dynamic equilibrium. In cybernetic terminology, this is about calibrating the system's thermostat.

The systems change gradually in response to the changing "requirements" from inner and outer environments

Dramatic re-organizations can be natural, self-regulating elements in the system's "lifespan"

Crises and destabilizations can initiate necessary re-organization processes that promote future and long-term equilibrium

Deficient capacity for adaptation to inner and outer changes lowers the threshold for the destabilization of the system

Failing self-regulation can be counteracted by increasing the supply of energy, remove the inner or outer strains and calibrate the system's thermostat

5. 1st and 2nd order change

To restore the ability for self-regulation through increasing the “same activity” or removing what was a problem, in cybernetics is characterised as 1st order change. 2nd order change is seen as change of the “thermostat’s setting”, which in a clinical context means changing the *understanding of* and *attitude towards* what the problem is. Access to both these strategies will give the system optimal adaptional and re-adjustment ability. If 1st order change is repeatedly tried without success, calibration of the system’s thermostat (2nd order change) will be necessary to maintain the system’s existence.

1st order measures entail an ambition to remove or reduce the problem

2nd order measures are about changing the *relationship to the problem*

A system should ideally be capable of re-establishing its ability for functional self-regulation if an actual strain is reduced to a level that can be overcome. A long-term crisis and deficient use of strategies for 2nd order change can damage or disturb the system’s “thermostat” or self-regulating “mind”. This will weaken the system’s qualifications for establishing and maintaining functional “set-values” concerning the type and amount of activity that may promote long-term self-regulation and stability. Flexible readjustment and adaptation to changed life circumstances naturally also will become more difficult.

Overloading a system over time can cause disruption and damage the system’s thermostat

6. Attachment style and dynamic equilibrium

6.1. The DMM model

From the BET perspective, the DMM (Dynamic-Maturational Model) shows how the manner in which people try to achieve dynamic equilibrium can be classified in four styles (Crittenden, 2008). In the *Type B attachment style* the individual, in the context of his relational experiences, can adapt in a nuanced and balanced way to situations and surroundings, make demands and express his needs. Reserved people lean towards *Type A attachment style*, while the more reactive lean towards *Type C attachment style*. The more a person suppresses (forbidden) negative emotions, engages in pretence, conceals themselves and allow themselves to be subdued (*Type A*) or overreacts, and issues threats and punishments (*Type C*), the worse the preconditions for self regulation. Both Type A and Type C can be separated into normative and more pathological styles. The most serious deviation from the balanced Type B and the normative Type A and C attachment styles is in the very pathological and dysfunctional integrated Type A/C attachment style. Type A/C entails that the patient conceals and is deceptive and at the same time is characterised by delusions, reactivity and acting out of behaviours. The typical Axis I and Axis II diagnoses (APA, 2000) that Type A, C and A/C patients, respectively, are given in health care institutions, is elucidated below.

The DMM model shows how different forms of pathological behavioural patterns connect to the person's attachment style

Type B attachment style produces the best conditions for functional self-regulation of affect and behaviour

Type A and Type C deviate in different ways from Type B attachment style and represent very different pathological pictures

Integrated Type A/C is the pathological counterpart of the balanced and well-functioning Type B attachment style

6.1.1. Type A attachment style

Patients with *Type A attachment style* fail to express pain and conceal their inner life from other people. They adapt, relinquish their needs and ensure that their own inner imbalance does not affect the greater system (relations, groups of people) and create imbalance at "higher" system-levels. Their fear of expressing forbidden negative feelings maintains and reinforces a state of strain (which is often concealed behind a forced positive style). That is how social situations are balanced, they stretch and stretch until an inner crisis occurs; they "implode" in acute internal chaos which then produces/ aggravates symptoms ("intrusions of forbidden negative affect"; Crittenden, 2008).

Type A patients try to maintain equilibrium by not acknowledging their needs and what they actually feel

Type A attachment style leads to a clinical picture that often is diagnosed as anxiety, depression or recurrent depressive disorder, dissociative disorder, and avoidant or dependent personality disorder. For lower symptomatic and functional levels some of these patients are erroneously diagnosed with schizoaffective disorder (depressive type) or paranoid schizophrenia. This is because they can exhibit recurrent auditory hallucinations and flashbacks following traumas, which are interpreted as delusions, and existential resignation that is interpreted as negative symptoms.

The use of categoric diagnostic systems can easily under or over-evaluate the severity of the Type A patient's pathology

6.1.2. Type C attachment style

Patients with *Type C attachment style* continuously express their

pain and their needs both verbally and non-verbally. They do not cover up, they do not adapt. They have expectations and make demands – the system that the patient is a part of has to adapt to him or her, not the other way around. If they manage to force the surroundings to respond by meeting their demands (through exaggeration, distortions, threats or helplessness), they may experience a better balance. But the state of equilibrium does not last ... it doesn't take long before new needs arise. The expectations recur and the patient continues to express their needs, often in a demanding and threatening way; they *explode* and create chaos in their relations and surroundings.

Type C patients try to maintain equilibrium by appealing, demanding and threatening their way to response- and need satisfaction

Type C attachment style seems to represent a clinical picture that is associated with what is called “borderline” in psychiatric healthcare. These patients often get diagnosed as emotionally unstable or with histrionic personality disorder. Due to fluctuations in mood some are considered to suffer from a bipolar II condition. For lower levels of symptoms and functioning it is not unusual for the patient to be diagnosed with schizoaffective disorder, mixed type. This is because cognitive functioning increasingly becomes influenced by delusions and/ or hallucinations, while the patient at the same time exhibit symptoms associated with either mania or depression.

Type C patients often present in a manner that health service staff associate with borderline

Instability can be understood as a bipolar disorder, and with lower functional levels, the incidence of cognitive symptoms emerges

Type A and C attachment styles represent different challenges for carers and staff in the handling of behavioural disturbances, in making therapeutic relationships and in developing a working alliance. See more about this in section 10. “Cybernetics as framework through the BET process” and 11.3. “Complementary external regulation”. The therapeutic objective to develop Type B attachment style in very pathological Type A and Type C patients is unrealistic. The objective of BET is that the patient develops a wider and more flexible coping repertoire through the corrective emotional and relational experiences they acquire from a secure base.

To turn all Type A and Type C patients into Type B attachment style would be an unrealistic goal

6.1.3. Integrated Type A/C attachment style

People with an integrated Type A/C attachment style are those who, in many situations are called psychopaths or sociopaths. If they are patients in mental health care institutions they are often diagnosed with dissocial or antisocial personality disorder. Due to special difficulties in establishing a therapeutic relationship and working alliance these patients are not candidates for BET. Inclusion and exclusion criteria for BET are described further in the manual “BET phase 2: Working alliance” (Heggdal, 2010).

Patients with Type A/C attachment style will not be able to make use of BET because exposure therapy requires commitment and working alliance

7. Schizmogogenesis as an explanation for malignant regression

7.1. Symmetrical and complementary relations

For two or more (sub-) systems to enter a self-regulating, functional macro system a dynamic interaction is required, in which the (sub-) systems mutually adjust to each other. If the totality of activity does not promote dynamic equilibrium in the macro system, what is termed *schizmogogenesis* in cybernetics develops. Development of schizmogogenetic processes can cause relations to collapse, such as the relation between two nations or two people. Below, the term schizmogogenesis is used to highlight what happens in the development of what is called malignant regression in psychodynamic psychology (e.g. Balint, 1968).

Schizmogogenesis can undermine the relational system's dynamic equilibrium

Cybernetics distinguishes between complementary and symmetric relationships. Complementary relationships are characterised by an interaction where one party's behaviour is met by the opposite or complementary behaviour of the other. Symmetrical relationships on the other hand are characterised by interactions where behaviour is met with the same type of behaviour from the other party (Bateson, 1972).

Schizmogogenesis evolves where interaction is characterized by mutually reinforcing behaviour

The dynamics of a complementary relation can be exemplified by

- *helplessness ("demand" for help) is met with protection and care*
- *aggression is met with evasion and reticence*

In complementary relationships one persons' behaviour is met with the *opposite type* of behaviour from the other person

In contrast, symmetric relations will be characterised by

- *helplessness is met with demand for independent behaviour*
- *aggression is met with aggression*

In symmetric relationships one party's behaviour is met with the *same type* of behaviour from the other party

7.2. Prevention of schizmogogenesis

If the complementary or the symmetric interactive form is the sole characteristic of relations between people (subsystems) over time, then *schizmogogenesis* arises in the macro system (Bateson, 1972). This means that the parties' behaviour in "the relational system" is mutually reinforcing, and a positive feedback loop is created by reactions and counter reactions. The relation enters into crisis, which can only be "resolved" by sufficient "doses" of the contrasting element (negative feedback).

Schizmogogenesis is counteracted by responses that break the self-reinforcing interaction dynamic

A schizmogogenetic complementary relation must be balanced by elements of symmetrical behaviour:

- *The person giving care facilitates independence (building a sense of responsibility)*
- *The evasive and reticent person faces up to aggression (self-assertion)*

In a schizmogogenetic complementary relation symmetric behaviour represents negative feedback

A schizmogetic symmetric relation must be balanced with elements of complementary behaviour:

- *The party demanding independence in the other obliges their helplessness (care)*
- *The party subjected to aggression is reticent (tolerance)*

In a schizmogetic symmetric relation complementary behaviour represents negative feedback

7.3. Two roads to malignant regression

Schizmogetic processes can thus, in two ways, lead relationships into what is called malignant regression in psychodynamic terminology:

- 1) *A complementary relation* characterised by repetitive satisfaction (gratification) of the patient's immediate needs (attention/ care) leads to positive feedback loops which end in (symbiotic) dependency
- 2) *A symmetric relation* characterised by demand and counter demand (mutual placing of responsibility on the other party) leads to positive feedback loops with aggression, helplessness and resignation as results

Malignant regression in a complementary relation leads to dependency

Malignant regression in a symmetric relation leads to rejection and distance

In psychiatric healthcare one is often only aware of the first type (pathologic dependency) with regard to the patient's regressive tendencies, and healthcare personnel can often unconsciously and unintentionally contribute to pushing the relation into the other camp (aggression/ resignation).

Health personnel can unconsciously and unintentionally contribute to malignant regression

According to cybernetic theory and schizmogetic mechanisms, preventing malignant regression is about combining complementary and symmetric responses in cooperation with the patient. This is a therapeutic balancing act that must be practised and perfected. It is also crucial how the patient's needs are met, and how the patient is made to take responsibility. The most important thing here is that the treatment situation is characterised by involved healthcare staff who show empathy throughout, while they at the same time place responsibility for what happens with the patient (see section 8.2. "Explanation of causes and instilling a sense of responsibility"). The patient's attachment style (*Type A* or *Type C*) also influences the strategies that best promote the therapeutic progress. See more about this in sections 10.1. "Secure base" and "11.3. Complementary external regulation" which are about facilitation of such therapeutic manoeuvres.

Knowledge and insight into schizmogetic mechanisms is necessary to prevent malignant processes

All measures are carried out in an empathetic way, expressed both verbally and non-verbally

Individualised approach based on the patient's attachment style is important for creating progress in the treatment

7.4. Malignant regression – in the patient or in the relation?

What is normally defined (punctuated) as a malignant state in the patient in the cybernetic perspective can be considered a product of interaction in the relational, therapeutic system (e.g. Geller, 1986). The helper's behaviour can also be punctuated as "malignant". This punctuation has legitimacy in the sense that it is the helpers who should have the overview and knowledge of the

From a cybernetic perspective malignant regression is not a characteristic in the patient, but the end product of marginalizing interaction processes

dynamics in the interplay. The health care workers are responsible for preventing schizmogetic development and breakdown in therapeutic relationships. With some patients, avoidance of such a malignant dynamic can be particularly difficult. Over time the result will be marginalisation and persistent dysfunction. An implicit goal of BET is to reverse such marginalising processes.

BET prepares for and invites interaction that gives the patient an opportunity to break the pathology- maintaining behavioural patterns

8. Specification of the rationale for the BET model

8.1. Marginalisation

The concept of “marginalisation” is used in BET about processes where the patient and the health care system as “cooperating companions” develop a state of ecological crisis. The patient tries to attain 1st order change in his everyday life: *Equilibrium shall be achieved through the avoidance of pain*. When the patient's avoidance strategies become increasingly dramatic and dysfunctional, the health service intervenes. The helpers have, however, the same goal: *to remove/ reduce the patient's pain*. Passing alleviation and/ or the helper's lack of alternative strategies lead to treatment still being based on 1st order interventions without the patient's ability for self-regulation being improved. In cybernetics, this is called “more of the same in the ecological crisis” (Bateson, 1972). “More of the same” refers to *positive feedback loops* in which the attempt to solve the crisis, both increases the crisis and counter to intentions becomes a part of the problem. A “marginalised patient” has a persistent and often increasing need for external regulation as the result of marginalised interaction with the health care system.

The patient is a system lacking the skills to self-regulate emotions and behaviour in a functional way

Marginalisation is the result of repeated failing attempts at 1st order change

A health service that one-sidedly emphasizes 1st order change can contribute to marginalisation

8.2. Explanation of cause and responsibility

When schizomogenetic mechanisms lead to marginalisation, causality may be attributed to the health service's “mistakes” or the patient's regressive tendencies and resistance to treatment. Both attributions are rather futile in therapeutic terms. The label “treatment resistant” increases the patient's chance of further marginalisation. As a victim of incompetence in the health care services, it will be difficult for the patient to take responsibility for the problem and solution, which Yalom (2002) prescribes as necessary for treatment to be effective. The cybernetic view of cause and effect as circular chains and loops of events provides the BET therapist with a starting point to pragmatically and rhetorically punctuate the problem so that the responsibility stays with the patient: psychological suffering is the result of the patient's avoidance of existential catastrophe anxiety. Thus, in its theoretical foundation BET is an approach that consistently assigns responsibility to the patient.

In a cybernetic perspective everything is connected in a web of interacting, self-regulating systems

Explanation of cause in BET is one of the many possible punctuations in circular chains of events

An explanation points out the cause of the system's imbalance and identifies the mechanism towards which therapeutic interventions are directed

Cause punctuation in the BET model involves the patient taking optimal responsibility

It is however important to make a separation between “guilt” and “responsibility”. For marginalised patients, the experience of the demand to take responsibility may easily result in regressive reactions (cf. paragraph 7, “Schizomogenesis as an explanation of malignant regression”). The therapist therefore must thoroughly validate the patient's feelings connected to relational traumas and combine this validation with an approving attitude towards all attempts at coping, no matter how dysfunctional those attempts might prove to be in retrospect.

The fact that the patient takes responsibility for the problem does not mean that it is the patient's fault that the problem arose in the first place

8.3. Calibration of the system's thermostat

According to the fact that life is and will remain painful, *avoidance*

of pain as “the final solution” is an impossibility. 1st order interventions may provide short-term and transient experiences of relief, but over time this possibly will lead the treatment process into a destructive *positive feedback loop* (“more of the same”). In this case the ideal (or idealised) state of equilibrium (freedom from pain) is even more unachievable. The lasting and marginalising destabilisation and inability to adapt that characterise the marginalised patient, requires an approach based on 2nd order change. By reformulating the problem, the focus of the approach to treatment is altered. In BET we say that the “system has a faulty thermostat”. As opposed to contributing negative feedback in the form of external regulation (reduction of pain), calibration of the system’s thermostat is the most purposeful and change-initiating strategy.

A “no pain” setting leads to *positive feedback loops* of avoidance and pain that further increases the system’s imbalance

BET aims to calibrate the system’s thermostat to reverse *positive feedback loops* and to counteract further marginalisation

9. BET rhetoric as a calibration tool

9.1. Reformulation of the problem

Reformulation of the problem is the first intervention to reverse what has developed into a vicious cycle of self-destructiveness (e.g. Watzlawick et al., 1974). In dialogues in the therapy room and at the ward it is communicated directly and indirectly that the cause of the suffering and dysfunction is not pain and fear: “*The problem is your attitude which says that pain and fear must and shall be avoided and your avoidance behaviour where all available means are used towards that objective*”. In a cybernetic language, such a reformulation has the purpose of “calibrating the thermostat” to “*acceptance of the fact that life is painful*” and “*acceptance of the experience of the pains that life might bring.*” This attitude makes superfluous the habitual efforts to avoid pain – the behavioural patterns which in reality *maintain* the state of being in pain. When the patient understands and gets used to the idea that the solution is to expose oneself to what one fears, as one does with elevator and spider phobias, a new way out of suffering is opened. In such a reformulation, it is important to underline the basic concept of making the patient take responsibility. The patient is now completely and utterly responsible for his or her own situation and future.

The calibration process is initiated by the reformulation of the problem

2nd order interventions make possible, paradoxically, what one tried in vain to achieve with 1st order interventions

Assigning responsibility also involves the patient taking responsibility for solving the problem

9.2. Emphasis on choice

Reformulation of the problem, that is, calibration of the system's thermostat, in BET amounts to a basic, irrefutable and consistent rhetoric manoeuvre: “You can choose to continue to avoid or to expose yourself to what you fear – your choice is decisive in allowing change to happen.” *To choose to be a choosing person is to step out of the victim role.* Furthermore, the choice of a “non-avoidance attitude” makes possible and prepares the way for phasing out the constant attempts at 1st order change. When the patient chooses actions that break with avoidance patterns, the associations, feelings and situations that used to initiate destabilising positive feedback loops will be “accommodated” in a new, more flexible and functional adaptation.

The therapeutic rhetoric in BET clarifies for the patient that it is now a question of decisively choosing his path

The patient can decide to be or not to be a victim of his own expectations of catastrophe

10. Cybernetics as superstructure through the BET process

10.1. Secure base

Seen as a system, the patient is a subsystem in the therapeutic relationship. The therapeutic relationship ideally has a system flexibility and adaptational ability that the subsystem alone does not possess. The subsystem's inability to self-regulate in a functional way is equalized or compensated for in the larger system. The imbalance in the subsystem however can also destabilise the therapeutic relationship, an imbalance that might or should be accommodated in a "larger" system, such as through supervision, for example. An introductory element of the treatment is "the therapeutic system's" primary task to regulate the patient like a destabilised subsystem. Further in the BET process, the main focus is on the development of the subsystem's functional self-regulation skills. At the same time, continuous external regulation can be necessary throughout the course of treatment and may also be necessary after discharged from the hospital.

Secure base means that the unstable system is enclosed by the larger, regulating system that protects against danger

On arrival at the ward, the patient is stabilised by adjusted external regulation

Early in the process the treatment's main focus is turned towards the development of autonomy

Type A and *Type C attachment styles* represent different therapeutic challenges in the establishment of therapeutic relations and also in the further process. When dealing with *Type A* patients, it is crucial to identify, confirm and recognize the patient's needs. *Type A* patients to a small degree will recognize negative feelings and expend a great deal of resources keeping these hidden from their own consciousness and other's focus. These patients therefore must be given time and space, where unacknowledged and unexpressed feelings to an increasing degree become the subject of investigation in the therapeutic relationships. When the patient's needs are met it can give him/her corrective, emotional and relational experiences. When it comes to *Type C* patients, it is also important to see, confirm and recognize their needs. It is however, crucial that the therapist structures the situations, sets the borders and defers satisfaction of needs to promote development of inner structure and rule governance (see paragraph "11.3. Complementary external regulation").

Type A attachment style requires that the patient gets the opportunity and time to explore, acknowledge and express their needs

Type C attachment style requires consistent boundaries and absence of responses that reinforce the patient's tendency to appeal, demand and threaten

In a behavioural therapy perspective, *Type A* patient's experience- and expression of needs is positively reinforced, while *Type C* patient's behaviour (demanding satisfaction of needs), is reduced by withholding reinforcement. In certain situations, both types of attachment styles periodically can "switch over" and appear as an expression of the opposed attachment style: The *imploding* *Type A* patient acts out (to escape unbearable emotions), and the *exploding* *Type C* patient resigns (gives up to get the desired response). However, the latter can also be a passive-aggressive manoeuvre. Such sudden changes can be a result of increased psychosocial stress and/ or of strains that the patient exposes himself for through the investigating and testing "new" coping strategies in the therapeutic process.

Type A and *Type C* patients are exposed to different behavioural therapeutic reinforcement conditions

A *Type A* patient can under strong and/ or lasting stress eventually appear as a *Type C* patient and vice versa

10.2. Working alliance

One of the chief elements in establishing a working alliance is education (Heggdal, 2010). The patient is informed about mental disorders as they are seen in the perspective of BET and the course of the treatment process is explained. In cybernetic terminology, this relates to setting in motion a “calibration” or “resetting” of the system’s thermostat through clearly and markedly reformulating the problem. The patient who previously had a mental set that prescribed the avoidance of pain now is set to begin a readjustment for accepting the experience of pain. This change of thermostat settings makes it possible to choose exposure instead of avoidance.

Through psychological education the thermostat is set at “acceptance of pain and experience of pain”

A major theme in the establishment of a working alliance is that the patient has a choice

10.3. Focus on avoidance

With a “changed thermostat setting” the patient prepares himself to do the opposite of avoiding. To be in a position to choose not to avoid, the patient must know what he/ she does in concrete terms to avoid, that is, the patient is made conscious of automatic avoidance behaviours and concrete actions that contribute to creating positive feedback loops. These actions and behaviours are attempted solutions that the patient uses to achieve equilibrium, and they constitute an attempt to set in motion negative feedback processes. But contrary to the intention, they lead to further destabilisation. Together with the therapist, the patient identifies the ways in which behavioural patterns and avoidant actions contribute to the circular chains of causes and effects. Focus is maintained on what the patient does. The patient’s reactions to what others do or have done are confirmed/ validated, but “external causes” will, in principle, be defocused. For the moment, the patient should not do anything except observe what effect conscious and unconscious avoidance has on the system (that is, the patient himself/ herself) and the system’s ability to maintain dynamic equilibrium.

The patient is made conscious of avoidance behaviour and automatic patterns of avoidance

If the patient externalise causes the responsibility is gently returned

The therapist accepts and acknowledges the patient’s need for avoidance

10.4. Exposure

With exposure the patient increasingly chooses behaviour in line with a changed thermostat setting. In the therapeutic process, exposure represents actual *negative feedback* in the system. This revolves around correction of the still active, destabilising, positive feedback loops of pain and avoidance behaviour that preserves the pathology and leads to marginalisation. In the safe therapeutic setting the patient gains access and opportunity to try out corrective actions previously associated with existential threat and catastrophe.

Exposure represents negative feedback which counteracts positive feedback loops and brings the patient out of “the ecological crisis”

Basal exposure can be seen as a learning situation where relating to pain as a part of life is more or less caricatured and taken to extremes. After hospital treatment is completed, complimentary elements such as self-exposure and functional diversion (described in more detail under paragraph “10.5. Solution-focused consolidation” and “11.2. Functional diversion”)

Exposure therapy is a caricaturised learning situation – avoidance is completely necessary to be able to function in a complicated reality

constitute the patient's strategies for maintaining self-regulation in a functional way. Choosing to avoid (functional diversion) is necessary in daily life outside hospital for the individual to adjust to internal and external environments.

10.5. Solution-focused consolidation

In the final phase of BET, solution-focused interventions are used to strengthen the patient's consciousness of "*the difference that makes a difference*" (exposure vs. avoidance). In the solution-focused approach, there is behavioural therapeutic reinforcement of self-exposure skills that the patient practises in everyday life. The purpose is to generalize functional choices of action. In cybernetic terminology, the subsystem itself now (autonomously) can use negative feedback (self-exposure instead of avoidance) to prevent marginalizing positive feedback loops. "*The difference that makes a difference*" is internalised in the patient and creates a basis for new and more functional behavioural patterns. This means that the subsystem can ensure dynamic equilibrium independent of a regulatory macro-system. At this stage, the patient is in the process of becoming independent of the frameworks of hospital department. To what extent BET continues after discharge depends on what the patient wants and whether he or she needs further consolidation of self-exposure skills.

The focus is moved from exposure in the consulting room and in therapeutic relationships to self-exposure in life outside the department

The regulated subsystem re-establishes autonomy by automatization and generalisation of self-exposing behaviour

11. General cybernetic elements in BET

11.1. Reflecting team

In treatment meetings, the method of *reflecting team* is used as a communication structure. The starting point for reflection and investigation is the common themes running through the BET process: establishing a secure base and working alliance; investigate/ create awareness of avoidance; carry out exposure interspersing with functional diversion; and consolidate self-exposure skills. All this is practised in a turbulent daily life where the risk to life and health constantly has to be taken care of. Under such circumstances, it is necessary to create structures that help raise the collective awareness to ensure that the treatment process stays on course, with a shared focus and optimal progress.

The reflecting team is used to establish focus, prepare interventions and evaluating the treatment process

The work process in the reflecting team is in itself a treatment coordinating intervention

The reflecting team defines problems connected to understanding, interventions and evaluation and works on the basis of those problem areas. The participants in the team have different professions, different backgrounds as well as different perspectives on the patient. In a cybernetic perspective, the participants' knowledge and understanding represents a spectrum of points of view with regard to systems that regulate the patient and/ or affect the patient's self-regulating activity. This setting, where any experience or thought unconditionally can be said out aloud, stimulates creativity and prevents difference of opinions from inhibiting patient work.

The team looks at current problems from every viewpoint to promote progress in the treatment

If the patient is motivated and ready he or she can also participate in the reflecting team. Alternatively, the patient is involved in the formulation and specification of problems prior to a reflecting team meeting and/ or in the follow-up work with the revision of the treatment plan. Inclusion of the patient's own understanding and perspective is of central importance with reference to making the patient the main actor in his own process. The reflecting team is seen as vital in the work with marginalised in-patients because the method contributes to establishing a common focus and sense of coherence for all participants in the treatment process.

The reflecting team is an ideal arena for making the patient the main actor in their own process

Therapy research shows that a clear focus and sense of coherence are central factors in effective treatment

11.2. Functional diversion

Exposure ideally occurs gradually in relation to principles for systematic desensitization. However, the patient may be temporarily destabilized when 1st order measures and habitual avoidance is replaced by the 2nd order strategies such as exposure. This happens because it can take some time before the circular chains of cause and effect that are altered during exposure therapy leads to new, stabilising patterns (Heggdal, 2008).

BET takes into account that patients temporary can be destabilised as a result of exposure

In the therapy room and at the ward, the imbalance that arises in the patient as a result of exposure is contained in the "relational

system". However, there are 24 hours a day, and even marginalised patients only in exceptional cases are continuously kept behind locked doors. Exposure work in BET is balanced therefore with the counterweight of *functional diversion*. This includes all activity that can represent stabilising negative feedback where the system is destabilised as a result of exposure. Functional diversion is therefore a consciously chosen avoidance that diverts the patient from unease and fear. During investigation of avoidance, this is emphasized in order to give the patient possibilities for "a break" and an experience of "having alternative strategies" when difficult situations arise in the process. Functional diversion is parallel to what is called coping, or coping with symptoms, in therapies that to a greater degree emphasize 1st order change. The difference is that in BET "coping" is used as a strategic means to achieve long-term 2nd order change and does not represent a therapeutic goal in itself. Functional diversion can be seen as a "conscious choice to avoid" in a process that aims to reduce the use of such strategies. This may seem paradoxical, but functional diversion is considered a useful and necessary system-stabilising factor in a process that moves forward, vacillating between stagnation and chaos.

Successful treatment requires that the patient takes "time outs" from the intensive treatment they go through

Making the patient conscious of the function of avoidance means that the patient can actively choose avoidance when everyday life requires it

Functional diversion is a counterweight to the destabilisation that may result from exposure

Functional diversion is not a goal in itself, but a necessary stopover on the road to functional self-regulation

11.3. Complimentary external regulation

One of the greatest challenges in therapeutic work with marginalised patients is to "dose" external regulation in a manner that promotes therapeutic progress. Many professional authorities will say that such patients should not receive long-term hospital treatment because the regulating activity of hospital wards promotes pathological dependency and increases behavioural disturbances.

Attempts at regulating "a bit" in hospital wards can lead to a malignant interactions between the patients and the helpers

There is no real alternative available to the marginalised patients who are prioritised for BET. The risk of serious damage to life and health is so great and lasting that hospital treatment emerges as the only appropriate solution. BET guards against the development or reinforcement of malignant reactions with what we call complimentary external regulation. This involves an exchange between follow-up regimes characterised respectively by under-regulation and over-regulation. Polarisation of follow-up regimes minimizes the occurrence of dysfunctional and self-destructive behaviour at the ward (including negative influences between patients). In this way, the treatment team maintains focus and progress in the treatment processes and makes sure that the therapeutic everyday situation is not continuously disturbed by dramatic events and situations.

In BET treatment, the follow-up of the patient is polarised into two complimentary regimes:

**Under-regulation
vs.
Over-regulation**

Complimentary external regulation makes everyday life at the ward manageable and prepares the way for focused exploration and exposure

In a cybernetic perspective, under-regulation can be seen to set the subsystem (the patient) in an inner state characterised by entropy, that is: a relatively high degree of "disorder" – inner looseness and overflexibility. Over-regulation sets the subsystem in an inner state characterised by negentropy, which means the opposite: a relatively high degree of "order", namely inner

Marked changes in the degree of external regulation puts the patient in an inner state that promotes mobilisation of the patient's resources

stagnation and rigidity. These therapeutic interventions mean that the macro-system (the ward) does *not* compensate (under-regulate) or compensate “too much” (over-regulate), respectively, with failing self-regulation on part of the subsystem. Both under-regulation and over-regulation put pressure on the subsystem to seek out dynamic equilibrium with its own resources and skills. This fundamental allocation of responsibility is a crucial behaviour therapeutic strategy in BET treatment.

Complimentary external regulation reduces the patient's dependence on a regulating macro-system

Under-regulation is applied as the primary strategy, in which the patient is taken care of and followed up to a lesser degree than a conventional evaluation of need for protection indicates. Examples here are lower follow-up status in the department (frequent inspection where there are indications that the patient should have somebody watching them constantly) and free access outside the ward (agreed outside access for 2 hours when it appears that the patient will only cope with half an hour). Functional choice of actions and coping is met with solution-focused interventions in which the goal is to increase the probability that such actions are repeated and that functional behaviour (coping) is generalised. When an under-regulating regime activates positive feedback loops of behaviour that maintain the pathological condition, this is met with curious exploration (“...what is happening now?”). If the patient is not in the right frame of mind or unable to explore and try out other coping alternatives, an immediate transition to over-regulation is carried out. Such an intervention is very important and effective in the treatment of patients that experience intense need for care, feel failed by everything and everyone and continuously blame the staff for not bothering with them or taking good enough care of them (cf. Type C attachment style).

Under-regulation is combined with solution-focused empowering interventions

If under-regulation is shown to destabilise the patient, this is met by initiation of an over-regulation regime

With over-regulation the stimuli is reduced and the tempo is lowered: we speak slowly and allow for a latent period before answering. Waiting time is put in with regard to practical things and doings and it is ensured that the patient is not entertained. Everything is done in a compassionate, curious and respectful manner. As soon as the patient invites dialogue about change in the external boundaries, we are available to hear what the patient thinks and suggests.

Over-regulation promotes an experience of boredom and the therapist awaits the patient's initiative to change the follow-up regime

Over-regulation provides the patient with an experience that there are no secondary gains by leaving the responsibility for dynamic equilibrium to the macro-system. With under-regulation, one avoids “running after” the patient. This hinders reinforcement of regressive behaviour and the development of pathological dependency. In a relatively short period of time, the patient will experience that being given a free rein is considerably more relationally stimulating and rewarding. Complimentary external regulation creates and/ or reinforces inner states in the patient (entropy/ negentropy) that set in motion and generalise cognitive and motoric activity, which in turn promotes dynamic equilibrium in the patient and in therapeutic relations. Complimentary external regulation is therefore an important strategic element in function-enhancing treatment of marginalised in-patients.

Complimentary external regulation minimises the secondary gains of dysfunctional behaviour

Through complimentary external regulation things quiet down and space is created to establish and maintain focus on therapeutic goals

12. Conclusion: Cybernetics – a difference that makes a difference

In the National Guidelines for the Prevention of Suicide in Mental Health Services (Norwegian Ministry of Health and Social Services, 2008) it is recommended that chronic suicidal patients are admitted only in crisis situations and that admissions shall be short-term. Of those patients described as chronically suicidal, the ones with the lowest functioning are marginalised patients with a level of functioning corresponding to GAF < 30 (APA, 2000). Being marginalised involves being in a chronic state of crisis. We are dealing with a group of patients considered to be treatment resistant at the same time as they take up a large number of in-patient places in hospital departments. Many of them in the marginalisation process will be described as “revolving door patients”. Even if some individuals may become increasingly stable over time, a considerable number of these patients find themselves spending more time inside than outside in-patient institutions as time passes. Treatment traditionally provided in hospitals to this group of patients is based mainly on alleviating symptoms and regulating behaviour via interventions that have little or no effect on the patient's ability to self-regulate.

In a 24-hour department, it is not the treatment itself that is expensive. The cost of wages makes up most of the budget. A marginalised patient admitted to a 24-hour department represents costs which amount to about 300 000 Euros annually. In a larger socio-economic perspective, there are additional costs related to somatic health services, necessary evacuations (ambulance, police), and burdens on the patient's next of kin and social network. This emphasizes the necessity to develop and implement effective methods for prevention and treatment within the mental health services.

BET is currently the only psychotherapeutic method developed specifically for the treatment of marginalised in-patients. The treatment model's solid basis in a cybernetic paradigm is considered to be a useful foundation for meeting the challenges this patient group represents. Cybernetics offers a perspective for identifying the problem and various approaches for function-enhancing interventions and prevention of malignant regression. The cybernetic view of cause and effect as circular chains and loops of events and the concept of self-regulation free the treatment process from the limiting power of categorical diagnoses and from controversies related to conflicting, linear explanations of causality (heredity versus environment, for example). Through reformulation of the problem and the emphasis on 2nd order change the patient is seen as a responsible active person. Medical interventions are used as a means to support the process rather than to alleviate symptoms. Cybernetics can therefore contribute to the effective treatment of a group of helpless patients who create helplessness also in the treatment apparatus.

National guidelines say that the treatment of chronic suicidal patients should not take place in a hospital department

The lower functioning segment of chronic suicidal patients are in an enduring crisis and are not in a position to take care of themselves

Marginalised patients are major consumers of 24-hour services in mental hospitals, but are seldom offered systematic function-enhancing treatment

In the specialist mental health care, a 24-hour place costs 300 000 Euros annually

Marginalisation incurs major costs on society, but the health services lacks effective methods for prevention and the treatment of these patients

BET is the sole treatment model to focus particularly on marginalisation and treatment of marginalised patients

To apply cybernetics as a foundation for the understanding and intervention is a difference that makes a difference

Experience from BET treatment suggests that chronic suicidal, marginalised patients can be treated in hospitals, and that intensive hospital care of this group can be cost-effective in the long term

13. Literature

American Psychiatric Association: Diagnostic and Statistical Manual. Washington, DC, APA, 2000

Balint M: The Basic Fault: Therapeutic aspects of regression. London, Tavistock Publications, 1968

Crittenden, P: Raising Parents. Attachment, Parenting and Child Safety, Devon, 2008

Bateman A, Fonagy P: Effectiveness of Partial Hospitalization in the Treatment of Borderline Personality Disorder: A Randomized Controlled Trial, Am J Psychiatry 1999; 56:1563-1569

Bateson G: Mind and Nature. London, Fontana Paperbacks, 1985

Bateson G: Steps to an ecology of mind. New York, Ballantine Books, 1972

Geller JL: In Again, Out Again: Preliminary Evaluation of a State Hospital's Worst Recidivists, Hosp Community Psychiatry 1986; 37:386-390

Heggdal D: Basal Exposure Therapy. Basic guidelines and principles. SSB, 2008 (Asker and Bærum State Hospital, Division of Mental Health – internet PDF)

Heggdal D: Basal Exposure Therapy. BET Sequence 2: Working Alliance – guidelines with inclusion and exclusion criteria. SSB, 2010 (Asker and Bærum State Hospital, Division of Mental Health – internet PDF)

Nurnberg HG, Suh R: Time-limited treatment of hospitalized borderline patients: Considerations. Compr Psychiatry 1978; 19:419-431

Rosenbluth M, Silver D: The in-patient treatment of borderline personality disorder. In Handbook of borderline personality disorders 1992, edited by Silver D, Rosenbluth M, Madison, Connecticut, International Universities Press

Norwegian Directorate for Health and Social Affairs: National guidelines for the prevention of suicide in the psychiatric health services, Oslo, 2008

Watzlawick P, Weakland J, Fish F: Change. Principles of problem formation and problem solutions. New York, W. W. Norton, 1974

Yalom ID: The gift of therapy. New York, Harper-Collins, 2002

Ølgaard B: Communication and eco-mental systems. An introduction to Gregory Bateson's work. Copenhagen, Akademisk Forlag, 2004