Effective Care of Treatment-Resistant Patients in an ISTDP-Based In-Patient Treatment Program

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Overall, few studies reported in the literature have focused specifically on non-responders to psychotherapy. Even fewer have specifically selected patients based on previous non-response to treatment and attempted systematic, customized psychological interventions to address their needs. Such studies could yield important information about strategies for overcoming the unfortunate fact that so many do not benefit from psychological treatments. The current study, and the treatment program it examines, was designed and implemented as an attempt to remedy this state of affairs. With the aim of relieving the suffering of patients with repeated non-response to treatment, an intensive, time-limited, residential treatment program was devised.

Using criteria for clinically significant change in symptoms,[1] the average recovery rate for formal psychotherapeutic treatments delivered in well-designed trials is approximately 50%.[2] Accordingly, approximately half the patients leave treatment with significant clinical symptoms or deteriorate during or after the intervention. In routine care (treatment as delivered outside of organized psychotherapy trials), the rates of recovery are substantially smaller.[3] Thus, a large percentage of patients in mental health care can be classified as "treatment-resistant" to psychotherapy. Given this, the development of new approaches specifically designed to aid these patients is of prime importance.

Due to lack of research, it remains unknown whether modifications in treatment format, setting, dose, or con-

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tent could improve outcome for these patients. Some studies have reported advances in the treatment of these challenging patients. For example, a recent naturalistic study of a 12-week residential, psychodynamic/ existential treatment program designed for treatment-resistant depression has shown promise. Patients in the program improved both interpersonally and symptomatically, and also significantly outperformed a group of matched controls receiving residential treatment as usual.[4] Furthermore, a 6-month residential program using an intensive short-term dynamic psychotherapy (ISTDP) approach in the Netherlands has demonstrated large and sustained therapeutic effects with treatment-resistant, personality disordered patients.[5] These studies provide some evidence that tailored residential treatment programs may be helpful for patients with treatment-resistant disorders.

An ISTDP format[6] was used as the basis for the individual psychotherapy patients received during their residential treatment. According to this model of treatment, psychopathology is understood as the inevitable consequence of failed integration of affect, cognition, and behavior[7] related to ruptured attachment bonds. There is a specific focus on the mobilization of warded-off, repressed, or avoided affect associated with these pathogenic ruptures with attachment figures, such that they can be activated and reworked directly within the therapeutic relationship.

Due to a surge in international interest, recent availability of high-quality training, and this model's clear conceptualization of the phenomena of resistance and consequent failure in treatment, ISTDP[7] was selected as the theoretical and technical basis for development of this program. ISTDP is one of the psychotherapy models in the literature that most clearly conceptualizes systematic work with treatment resistance.[7,8] This model offers a conceptually integrated

intervention system directed at dealing with both conscious and unconscious maneuvers that prevent genuine emotional closeness; minimize strong affect; and leave the patient in a passive, helpless, compliant, or defiant position *vis a vis* the therapist. Such defensive processes are considered the principal obstacles to therapeutic engagement and improvement, contributing to eventual treatment failure if not identified and challenged.

A number of case series and randomized, controlled trials[9] suggest that ISTDP is highly effective in the outpatient treatment of complex and resistant patients. A report from the UK's Pathfinder project demonstrated that ISTDP achieved good treatment effects in patients who had proven resistant to all other treatment efforts.[10] ISTDP has been shown to be effective

with patients suffering from treatment-resistant depression,[11] chronic somatic conditions, functional movement disorders,[12] chronic pain,[13] and medically unexplained symptoms (in patients with frequent emergency room visits).[14] It has also been found effective in treating people with severe mental disorders in a psychiatric hospital. In this sample, there was a significant reduction in self-reported symptoms/interpersonal problems, along with a significant reduction in need for electroconvulsive therapy.[15]

The present study was designed to investigate the effectiveness of an ISTDP-based, time-limited residential treatment program for relieving treatment-resistant disorders in a sample of 35 patients. The study examined changes in target complaints, general symptom distress, and interpersonal functioning during and after 8 weeks of residential treatment, as

TABLE 1.

Inclusion and Exclusion Criteria for Participation in the Study

Criteria of Inclusion	Criteria of Exclusion
Adults (aged 18-70 years)	Psychotic disorders[d]
Need for hospitalization for psychiatric[a] treatment	Bipolar disorder type I
Treatment-resistant disorder[b]	Dissociative identity disorder
Capacity for taking an intrapsychic view on problems during evaluation session[c]	Addictions needing detoxification[e]
	Disorders secondary to known medical conditions
	Mental retardation
	Insufficient command of the Norwegian language
	Acute suicide risk
	History of severe acting out

[a]Insufficient general functioning, loss of function in multiple domains (eg, inadequate self-care, severe breakdown in relational and/or occupational functioning).

[b]Previous failure to respond (in terms of significant symptomatic relief) to three or more prior treatment attempts for the ongoing psychiatric disorder.

[c]Ability to regard problems as result of difficulties in dealing with feelings, thoughts, and reactions to self/others in response to dialogue about what problem the patient wants help for.

[d]Except short, reactive psychotic episodes.

[e]After which entering treatment is possible.

well as at 1 year follow-up. Effect sizes, and the number of cases with clinically significant improvements, are presented. Possible implications for the treatment of treatment-resistant disorders and future research are discussed.

METHOD

Data were obtained from the Process and Outcome of Intensive Short-term Dynamic Psychotherapy for Treatment-resistant Disorders in Residential Care,[16] a naturalistic study of the effectiveness of an in-patient psychiatric treatment for patients with treatment-resistant disorders.

SAMPLE CHARACTERISTICS

The first 35 patients consecutively admitted to the unit comprise the sample for the present study. Criteria of inclusion and exclusion are listed in Table 1 (see page 517). Patients' mean age was 39 years (SD: 9.6, range: 21-58), 52% were female. Seventy-one percent had affective disorders, 77% had anxiety disorders, 29% had somatoform disorders, 26% had substance related disorders, and 6% had eating disorders. A total of 65% had one or more personality disorders (Cluster C: 35%, Cluster B: 11%, Cluster A: 5 %, NOS: 14%).

PROCEDURES

Eligible candidates completed an evaluation session with a therapist on the unit. Coordinators informed, assessed, and accepted the patients into treatment based on their response to the interview (see Table 1, page 517, for specification). In addition, *Diagnostic and Statistical Manual of Mental Disorders*, fourth edition, text revision (*DSM-IV-TR*) diagnoses were determined by trained assessors. The MINI[17] was used for assessing Axis I diagnoses. The SCID-II was used for assessing Axis II disorders.[18]

Patients completed questionnaires prior to treatment, after sessions three and eight, at termination, and again at 6 and 12 months post-treatment. In addi-
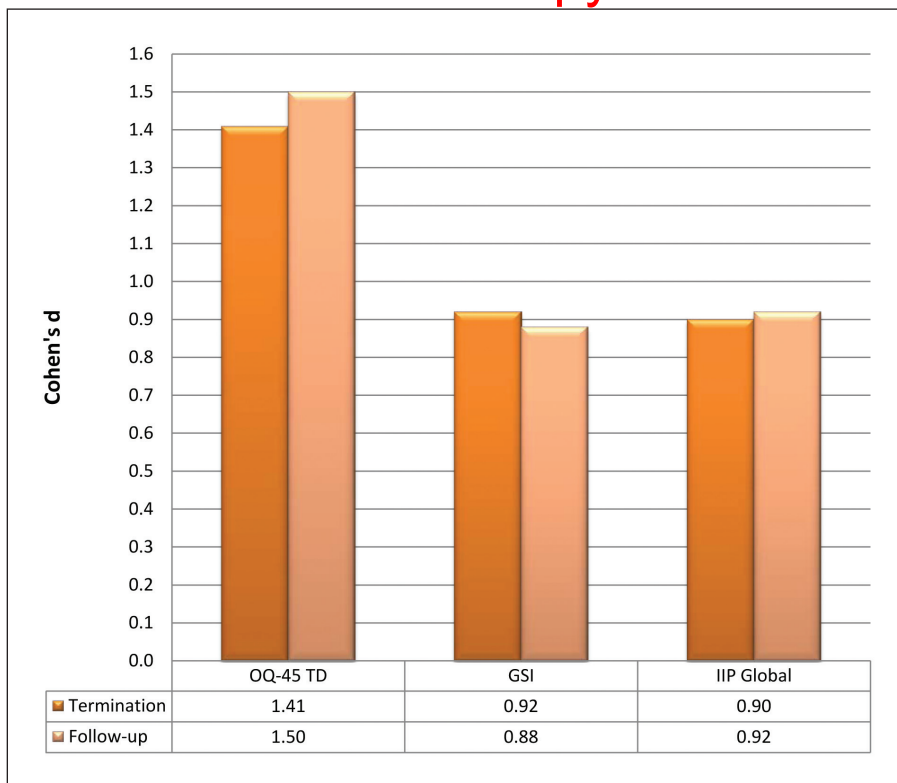

Figure. Effect sizes for patients at termination and 12-month follow-up compared with pretreatment scores across the three outcome domains. IIP Global = Overall level of Inventory of Interpersonal Problems; GSI = Global Severity Index; OQ-45 TD = Total Distress score on the Outcome Questionnairre-45.

	OQ-45 TD	GSI	IIP Global
Termination	1.41	0.92	0.90
Follow-up	1.50	0.88	0.92

tion, a 45-item measure of target complaints was administered prior to individual treatment sessions.

Treatment Program

The program was delivered at the psychodynamic unit at Thorsberg, the Residential Facility of the Drammen District-Psychiatric Center, in Norway. The program consisted of an 8-week residential intervention, wherein a number of treatment components were delivered. Treatment components were all integrated within the theoretical frameworks of ISTDP and affect integration theory.[6,19] Patients entered in groups of up to six (minimum four). They received two individual ISTDP sessions per week, in addition to biweekly group sessions based on principles from ISTDP. Other therapies in the residential program included weekly body-awareness groups; psycho-educational lectures; and biweekly, low-intensity physical exercise.

Therapists

Five therapists delivered the individual treatment. All were certified psychologists. Therapists participated in a 3-year ISTDP training program throughout the course of the study. Peer supervision took place on a weekly basis. Internet-based case supervision was provided every 2 to 3 weeks.[20] The clinical experience of individual therapists ranged from 2 to 6 years. The two group psychotherapists were highly experienced and certified in psychodynamic group psychotherapy. The body-awareness instructor was highly experienced and certified in psychomotor physiotherapy.

MEASURES

Target complaints were assessed with the Total Distress score (TD) of the Outcome Questionnaire 45.2. The OQ-45.2 measures symptoms of anxiety and depression, interpersonal distress, and problems in social role functioning.[21]

TABLE 2.

Results of Multilevel Growth Curve Analysis: Mean Estimates of Intercepts and Rates of Change in Target Complaints, General Symptoms, and Interpersonal Problems During Therapy and Follow-Up

	OQ-45 Total Distress		GSI of the SCL-90-R		IIP-64 Global Score	
	Model 0	Model 1	Model 0	Model 1	Model 0	Model 1
	Estimate (SE)	Estimate (SE)	Estimate (SE)	Estimate (SE)	Estimate (SE)	Estimate (SE)
Fixed Effects						
Intercept	100.83* (3.76)	100.74* (3.56)	1.47* (0.09)	1.46* (0.01)	1.65* (0.08)	1.65* (0.09)
Logtime	-33.33* (3.10)	-32.83* (4.39)	-0.54* (0.07)	-0.54* (0.10)	-0.48* (0.06)	-0.47* (0.07)
	Estimate (SE)	Estimate (SE)	Estimate (SE)	Estimate (SE)		Estimate (SE)
Residual	223.93* (28.74)	139.46* (20.92)	0.15* (0.02)	0.11* (0.01)	0.10* (0.01)	0.08* (0.01)
Variance in intercept	281.72* (82.70)	306.52* (107.44)	0.20* (0.06)	0.28* (0.08)	0.16* (0.04)	0.23* (0.07)
Variance in slope	–	448.24* (163.31)	–	0.21* (0.08)	–	0.09* (0.05)
AIC	1353.77	1335.44	263.69	250.86	193.08	189.73

Note: Estimations were done by the method of restricted maximum likelihood (REML).

*P < .01. Model 0 on each outcome variable keeps rates of change constant across patients, whereas Model 1 allows rates of change to vary. As can be seen by the significant variance in slopes for all outcome variables and corresponding decreases in the AIC- fit index from Models 0 to 1, Model 1 is preferable in all cases.

AIC = Akaike's information criterion; GSI = Global Severity Index; IIP-64 = Inventory of Interpersonal Problems; OQ-45 = Outcome Questionnairre; SCL-90-R = Symptom Checklist-90-R; SE = standard error.

The TD summarizes the principle complaints that the treatment program was developed to relieve. Cronbach's alpha for the TD was .92.

General symptom severity was assessed with the GSI of the SCL-90-R.[22] Cronbach's alpha for the GSI was .97.

Interpersonal problems[23] were assessed with the IIP-64. The mean score was used as an indicator of general interpersonal problems (IIP-Global). Cronbach's alpha for the IIP-Global was .93.

STATISTICAL ANALYSES

Multi-level modeling was applied to the data, using the linear mixed-models option in the SPSS/PASW, 18.0. Multi-level modeling for the analysis of longitudinal data has been recommended in the literature.[24] In the current study, all patients were assessed three or more times during treatment and follow-up. There was no attrition from the initial sample, and all cases are included in the data analysis. Therefore, there is little bias of outcome estimates due to dropout or otherwise missing data.

Inspection of individual plots and examination of R2-values for linear and nonlinear trajectories indicated that a logarithmic model would best fit the data.[24] Linear and log-transformed time variables were compared according to goodness of fit (Bayesian Information Criterion - BIC). For all outcome variables the logarithmic model outperformed the linear. Hence, a Lg10-transformed time-variable (logtime) was adopted.

The analyses investigating change on the three outcome variables began by computing a model containing the fixed effect of the time variable and a random effect of the intercept (model 0). Then, a random effect of time was added, allowing developmental slopes to vary independently across patients (model 1).

Effect sizes (Cohen's d) were calculated by dividing change scores by their corresponding pooled standard deviations. Cohen's standards[1] were applied (small effects; $d = 0.2 - 0.5$; medium effects; $d = 0.5 - 0.8$; large effects; $d > 0.8$).

Percentages of patients achieving clinically significant change (CSC) at termination and follow-up were computed. CSC operationalizes whether patients return to normal functioning[1] and occurs when 1) patients move from a dysfunctional population to a normal population during treatment and 2) the magnitude of change is statistically reliable. Patients who meet these criteria are classified as recovered. Other possible categorizations are reliably improved, not recovered; unchanged; or deteriorated, in the case of reliable negative change. Outcome scores in the study were compared to community samples.[25-27]

RESULTS
Effectiveness

Results of multi-level models for outcome variables are presented in Table 2 (see page 519). There were statistically significant improvements on all measures during treatment. Improvements were sustained 1 year after treatment.

For the TD-score (OQ-45.2) the intercept (mean baseline value across patients' individual growth curves) was 100.74. Overall change across treatment and follow-up was a reduction of 32.83 points. The rate of change during the treatment phase was a decrease of 3.89 points each week, and a continued decrease of 0.037 points per week during follow-up.

For the GSI, the intercept was 1.46. Overall change across treatment and follow-up was a reduction of .54 points. The rate of change during treatment was a decrease of .064 points per week. Follow-up scores, on average, decreased by .0007 points per week.

For the IIP-Global, the intercept was 1.65. Overall change across treatment and follow-up was a decrease of .47 points, yielding a rate of change during treatment of .056 points per week. During follow-up there was an average decrease of .0005 points per week. The continuing improvement in the follow-up phase was not statistically significant for any of the outcome variables.

Effect Sizes

The Figure (see page 518) displays the effect sizes for outcome variables at termination and 12 months follow-up. The TD score displayed the largest effects, with the GSI and IIP-Global having somewhat smaller, practically identical effects. Effect sizes remained stable at termination and 1 year after treatment. All effects were large according to Cohen's standards.[28]

Clinically Significant Change

Percentages of patients in categories determining the clinical significance of

TABLE 3.
Changes in Clinical Status from Baseline to Termination and 12-Month Follow-Up of Patients with Treatment-Resistant Disorders Who Received the 8-Week Treatment Program

Measure and Status	Percentage of Patients	
	Baseline to Termination of Treatment	Baseline to 12-Month Follow-Up
OQ-45.2		
Recovered	43	49
Improved[a]	37	37
Unchanged	20	14
Deteriorated	0	0
SCL-90-R		
Recovered	37	37
Improved[a]	46	49
Unchanged	14	11
Deteriorated	3	3
IIP-64		
Recovered	26[b]	31[b]
Improved[a]	37	35
Unchanged	37	34
Deteriorated	0	0

[a] Includes cases that were reliably improved, but that did not satisfy criteria for recovery, i.e. cases that were not below cut-off at termination or follow-up or that were below cut-off at the onset of treatment.

[b] When restricting the analysis to patients in the dysfunctional range at baseline, recovery rates on the IIP-64 increase to 33 % at termination and 41 % a year after treatment.

IIP-64 = Inventory of Interpersonal Problems; OQ-45 = Outcome Questionnaire; SCL-90-R = Symptom Checklist-90-R.

outcomes at termination and 1 year later are shown in Table 3. Forty-three percent of patients were considered recovered on the OQ-45.2 at termination. This increased to 49% a year later. The increase in the percentage of recovered cases did not reach statistical significance ($P = 0.614$, z-test). Percentage of patients unimproved dropped from 20 to 14 from termination to follow-up (not statistically significant; $P = 0.504$). However, the increase in recoveries and decrease in unimproved cases demonstrate that a number of patients improved in terms of target complaints after termination. Eighty-three percent of patients showed reliable improvement on target complaints at termination, and 86% were reliably improved a year after treatment (non-significant increase; $P = 0.728$). No patients deteriorated on the OQ-45.2 at termination or follow-up.

The percentage recovered on the SCL-90-R remained stable at 37 from termination to follow-up; 17% were either unimproved or deteriorated at termination, dropping to 14% a year after treatment (non-significant decrease; $P = 0.728$). One patient had a deteriorated score on the GSI, whereas 80% of patients reported reliable gains on the GSI at termination. This increased to 86% a year after treatment (non-significant increase; $P = 0.504$).

On the IIP-64, the percentage recovered was 26% at termination, increasing

to 31% a year after treatment (non-significant increase; $P = 0.643$). Thirty-seven percent were unimproved at termination, dropping to 34% a year later (non-significant decrease; $P = 0.793$). Sixty-three percent reported reliable improvements at termination; 66% reported reliable gains a year after treatment (non-significant increase; $P = 0.793$). No patients deteriorated on the IIP-64.

DISCUSSION

The present study suggests that an ISTDP-based, in-patient treatment program can be highly effective for alleviating treatment-resistant disorders. Treated patients reported substantial reductions in overall symptomatology, general interpersonal problems, and target complaints (anxiety/depression, relational distress, social role dysfunction). Effects were large, rapid, and sustained a year after treatment. Thirty-one to 49% of patients were recovered at follow-up, and 63% to 86% were reliably improved; remarkable rates for patients who had been non-responders to previous treatments. Intensive psychodynamic time-limited residential treatment (ISTDP-based in this case) may be a very helpful alternative for patients who fail to respond to the usual formats of treatment. This is supported by findings from two previous studies on similar populations.[4,5]

Interestingly, improvement happened within 8 weeks, indicating that highly intensive residential treatment may not only increase effectiveness of treatment efforts, but may also produce an increase in the swiftness of improvement as compared with standard out-patient psychotherapy.[2] These findings suggest substantial implications for the delivery of mental health care. It may be that, for this population, more expensive in-patient treatment will pay off in the end and be preferable to more economical, but less effective out-patient treatment. Additional measures of cost would be important in future studies looking at such issues as reduced disability, reduced hospitalization, medication use, and provider visits.

Strengths of the present study include delivery of treatment in a naturalistic setting; selection of patients with treatment-resistant disorders prior to intervention; inclusion of patients with comorbidity on Axis I and II; Multiple-outcome measures, allowing for multi-level modeling with individual growth curve analyses, increasing the reliability of findings; and calculation of clinically significant changes so that the clinical utility of effects can be assessed.

Limitations included small sample size and lack of a control group. Thus, coincidental improvements cannot be completely ruled out, though patients' previous treatment results make chance less likely as cause of reported gains. The fact that these patients had been suffering for many years and were unimproved after multiple treatments allows them to act as their own controls.

Future studies should include larger samples and randomized assignment of patients with treatment-resistant disorders to an intensive residential treatment and treatment as usual in order to determine relative effectiveness.

ACKNOWLEDGMENTS

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