Office Based Research in ISTDP: Data From the First 6 Years of Practice

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Allan Abbass, MD, FRCPC, Director of Education Department of Psychiatry, Dalhousie University, Halifax, Canada.

In this report, I will review office-based data from the first 6 years of practice in Intensive Short-term Dynamic Psychotherapy (ISTDP). The objective of this paper is to highlight the broad spectrum of patients suitable for ISTDP, the outcomes of different patient categories, and the cost effectiveness of this therapy. Finally, I will discuss the benefits of monitoring patient outcomes.

Office Settings 1991-1997

The case series' in this paper were derived from patients seen during my first 6 years of practice with ISTDP. Most of these cases were seen and treated from 1995-1997, my 3rd to 6th years of training, after I had established a psychiatric practice. This was a group practice in an affluent part of Vancouver, Canada, a city of over 1 million people. Most referrals (85.5%) were from family doctors and other psychiatrists. The remaining referrals came from specialist physicians, other groups of professionals or were self-referred. In this setting, psychiatrists are secondary and tertiary level care providers, and typically see patients who have had treatment trials of medications, psychotherapy or both.

ISTDP Training Background 1991-1997

As a family physician, I was fortunate to be able to train at the ISTDP training program in Montreal, Canada from fall 1991 to summer of 1992. During this time I had approximately five hundred hours of teaching, which included observing Dr. Davanloo conduct live interviews, studying tapes from his treated cases, interviewing patients, self-supervised tape review, videotape supervision and studying ISTDP articles. This represented a large volume of my ISTDP training at the start of my career.

This awesome experience lead me to do Psychiatry training so I could teach physicians, conduct research and contribute to the field of ISTDP. From 1992- 1997, I received approximately fifteen training blocks, totaling sixty days, with Dr Davanloo. I started teaching others during my residency program in 1993, and went on to develop a training program at University of British Columbia in 1995. By the end of 1997 my teaching experience encompassed over twenty seminars/workshops and twelve 20-50 hour courses in ISTDP. As Davanloo taught, teaching is a component of one's training because each element of teaching, i.e. preparing materials and interacting with trainees, is an educational experience.

Psychiatric Office Assessments for ISTDP: Suitability and Patient Category

Davanloo has described the breadth of patients suitable for ISTDP in accordance with 2 spectra. (1) Together, these spectra encompass the range of patients who are suitable for ISTDP.

The first spectrum is called the “Spectrum of Psychoneurotic Disorders”(SPN). Patients at the extreme left of this spectrum have only grief in the unconscious related to losses. There is an absence of rage, guilt about rage and self-destructiveness. At the extreme right of the spectrum, patients are highly resistant and complex, having suffered extensive trauma in the early phases of life. These patients have intense grief, primitive murderous rage and guilt in relation to loved ones, which results in a self -destructive system. As one moves from left to right between these 2 extremes, there is an increase in trauma, painful feelings, rage, guilt and subsequent resistances. (1)

The second spectrum is the “Spectrum of Patients With Fragile Character Structure” (SPFCS). This spectrum includes patients who experience cognitive and perceptual disruption when anxious. They have been heavily traumatized and have a lack of affectionate bonds to compensate for the trauma. Patients classified within this spectrum use a wide range of primitive defenses. This spectrum goes from mild to severe fragile character structure depending on how low the threshold is for cognitive and perceptual disruption. (1)

What are the rates of these patient categories in a psychiatric office? In an office sample of 342 consecutive consultations, 86.3% were candidates for a trial of ISTDP. The main contraindications included active substance dependence, organic brain syndrome, psychotic disorder and severe depression. Table 1 shows the sample and the classification of this population according to the 2 spectrums. The great majority (>80%) of patients were from the right side of SPD and from SPFCS. Very few (<5%) were low resistant or highly responsive. All but the 1% at the extreme left had some degree of unconscious rage and guilt about the rage.

Table 1: Categories of Candidates for Trial of ISTDP: N = 342 Consultations

Category	N	Percent of Referrals
Extreme Left	3	0.9
Mid Left	10	2.9
Mid Spectrum	35	10.2
Mid Right	102	29.8
Extreme Right	61	17.8
Mild Moderate Fragile	64	18.7
Severe Fragile	20	5.8
Contraindication	47	13.7
Total Suitable For ISTDP Trial	295	86.3

Analysis of a Treated Sample of 166 Patients

166 of these 342 patients went on to have a trial of ISTDP within these first 6 years of practice. Their demographics and diagnostic categories are shown in Tables 2a and 2b. These numbers reveal a fairly impaired group, most of whom had more than one diagnosis.

Table 2a. Description of Sample N=166

Mean Age	37.8 years
Female/Male	48% / 52%
Referred on Psychotropic Medications	48.2%
Duration of Continuous Medication Use	23.3 mo
Unemployed or Disabled	18.7%
Duration of Unemployment/ Disability	26.1 mo

Table 2b. DSM Diagnoses

Diagnosis on DSM IV/ IIIr	**Percent of 166 Referrals**
Major Depressive Disorder	36.3%
Generalized Anxiety Disorder	31.5%
Dysthymic Disorder	31.5%
Panic Disorder	31.5%
Post Traumatic Stress Disorder	20.2%
Agoraphobia	14.2%
Eating Disorder	10.1%
Substance Dependence	8.9%
Social Phobia	8.9%
Dissociative Disorder	8.3%
Obsessive Compulsive Disorder	4.7%

The patient categories, occupational status, medication status and treatment responses are shown in Table 3. This sample had almost the identical composition of the total sample of 342 referred (Table 1), thus, we can consider it representative of the referral population. This sample was fairly impaired, with an 18.7% rate of unemployment and 48.2% rate of non-response to medications.

Progressing across the spectrum, there are increases in medication use, duration on medication, unemployment, and duration of unemployment. Hence, this data validates the concept of a spectrum of increasing disturbance and dysfunction.

One can see that the great majority (80%) of patients were highly resistant from the right side of the SPD and from the SPFCS. Conversely, very few patients were low resistant with ability to respond to interpretive therapies. This corroborates Davanloo's findings that the preponderance of patients seen are highly resistant and complex. It is for this reason Davanloo needed to

develop his powerful system with the versatility of a preparatory phase for low anxiety tolerance patients (2, 3) and techniques to overcome the highest levels of character resistances (4, 5).

Davanloo's system of ISTDP must be considered the most powerful psychotherapeutic system in existence, if only considering the massive volume of patients treatable within this system.

Table 3. Description of Sample by Patient Category

Specturm	Treated Patient % (N)	% On Medication	Duration of Medications (mos)	% Off Work	Duration Off Work (mos)
Left Spectrum	2.4 (4)	25.9	12.0	25.0	1.0
Mid Left	5.4 (9)	44.4	13.3	11.1	7.0
Mid	12.1 (20)	45	12.0	15.0	1.7
Mid Right	41.0 (69)	52.9	11.64	11.8	5.6
Extreme Right	15.7 (26)	30.7	9.7	19.2	19.8
Fragile	24.7 (41)	64.9	66.5	37.8	48.6
Total Sample	100 (166)	48.2	23.3	18.7	26.1

Office Outcomes by Patient Category

The outcomes of these 166 patients is summarized in Tables 4 a and b. The overall patient self-report outcomes show robust improvements with clinical normalization and high statistical significance. There is relatively less dramatic improvement as one moves across the treatment spectrum. The same applies for the rate of response with no relapse: there is a decreasing rate of response as one goes across the spectrum.

The drop out rate was relatively low at 6.6%, considering these were the first 6 years in psychotherapy practice. These 11 dropouts appeared due to a lack of perception of improvement in 4 cases, increased anxiety in 3 cases and a move in one case. The other cases would appear to be a combination of misalliance and other factors. In my assessment, all these patients were either highly resistant from SPD or SPFCS. They had had a mean of 12.2 sessions before leaving therapy.

The non-response rate was also relatively low at 7.2%. With 6 patients, the resistance was beyond my, and our, capacity to manage. Two had major depression, and, they both responded to medication and a more cognitive format of STDP with benefits including return to work. A third had an agitated depression and was referred to me for hospital admission: ultimately he was admitted to hospital. Two were actively pursuing legal actions and were of mixed motivation to improve. One had a learning disorder. One was substance dependent taking an extremely high dose of sedative medication. In spite of these factors, I considered these patients as candidates

for a trial of ISTDP: I suggest that the major reason treatment failed was due to my own technical short-comings. These efforts averaged 8.0 sessions.

The return rate was 6.6%, consisting of only highly resistant SPD and SPFCS patients. Six of these patients had major depression: they relapsed but to a lesser extent than the first time. Three patients had congenital neurological problems. One had schizoid personality disorder and a family history of schizophrenia. In 4 cases, it appears there were inadequate changes brought during the therapy process. In the others, it appears that improvements did not persist for other reasons. Two started medications, while 2 had medication adjustments. The average number of sessions was 34.7.

The overall rate of response without relapse or return in the following 1.75 years was 80.1%. Only 6 patients required starting of medications at any point.

Table 4a. Outcomes by Place on Spectrum

Spectrum	Left	Mid Left	Mid	Mid Right	Extreme Right	Fragile	Total Sample
Treatment Length in Complete (Hours)	1.0	2.7	7.9	14.7	13.5	40.4	16.9
Symptoms Normal at Completion (1) (%)	100	100	100	69.2	82.4	59.0	86.1
Symptoms Statistical Improvement (t test, p value)			*<.001	$<10^{-8}$	<.001	<.01	$<10^{-14}$
Interpersonal Problems Normal at Completion (2) (%)	100	100	100	70.0	85.7	45.5	64.7
Interpersonal Problems Statistical Improvement (t test, p value)			*<.01	<.001	<.001	.12 (n.s.)	$<10^{-7}$

* These data included the extreme left, mid left and mid spectrum patients in order to have a sample size of greater than 20 for analysis.

1. Brief Symptom Inventory (BSI). Normal Cutoff=50
2. Inventory of Interpersonal Problems 64 (IIP). Normal Cutoff at 1 SD above normal mean

Table 4b. Sample Outcomes by Place on Spectrum: Part 2

Spectrum	Left	Mid Left	Mid	Mid Right	Extreme Right	Fragile	Total Sample
Return to Work (%)	100	100	100	100	80	64.2	80.6
How long to RTW (mos)	1	1	1	3.4	3	5.8	4.2
Stopped all Medications (%)	100	100	88.9	67.6	25	50	69
How long to stop medications	1	1.7	1.8	2.3	3.25	2.25	4.2
Non response rate (%)	0	0	0	8.8	11.5	4.9	7.2
Drop out (%)	0	0	0	5.9	11.5	9.8	6.6
Relapse or return rate (%)	0	0	0	5.9	15.4	9.8	6.6
Response with no return (%)	100	100	100	85.3	80.8	75.6	80.6

How did patients do during the waiting period?

At the latter end of these 6 years of practice, patients were asked to complete outcome questionnaires before and after the waiting period. This served as a naturalistic control group. The average wait period for these 17 patients was 23.6 weeks. This was longer than the treatment period of 16.9 sessions in completers. This difference did not reach statistical significance with p = .24.

None of the measures showed any significant changes during the wait period: all the mean ratings were in fact worse after the wait than they were before the wait. This may be a result of the bias introduced by only having measures for patients who waited for treatmentversus those who either improved spontaneously or sought other therapies during the wait period. Conversely, this suggests that the patients who waited for treatment were non-responders to treatments tried during the waiting period, thus, a more challenging to treat population. See Table 5 for details.

Table 5: Response to Wait List

	Brief Symptom Inventory	Inventory of Interpersonal Problems	Beck Depression Inventory	Beck Anxiety Inventory

Number of Ratings	17	17	8	8
Pre Wait	74	88.5	12.6	12.9
Post Wait	80.8	95.4	17.3	17.4
Significance (t test, p value)	.95	.82	.53	.75

This lack of improvement on wait list was replicated in a later office sample of 24 patients. In another systematic wait-list controlled study we are conducting, there are no significant improvements in wait periods averaging 10 weeks. (6)

This finding speaks to Davanloo and Malan's writings (7) that an optimal study design may be the wait-list controlled study. This design allows the improvement of symptoms to be more clearly attributable to the therapy versus the passage of time.

Did Unlocking the Unconscious Make a Difference in Outcomes?

Another way to examine this data is to ask whether "unlocking the unconscious" (8) has any impact on outcome measures. Available data was used to compare the therapist's view of treatment events with patient self-report outcomes and health outcomes data in follow-up. To answer this question, a series of 89 patients who had government-provided cost data (9) was broken down into the following three groups:

Group 1) Repeated Unlocking

These patients had experienced repeated unlocking of the unconscious. These 57 patients had a mean of 16.3 sessions. 37 of these patients were highly resistant or fragile.

Group 2) Rise in CTF/ Partial Unlocking

These patients had a rise in the complex transference feelings (CTF) with or without partial breakthroughs of feelings. These patients had no major unlocking of the unconscious. These 16 patients had a mean of 11.0 sessions. 13 of these 16 patients were highly resistant or fragile.

Group 3) Low or No Rise In CTF

This group had little or no rise in the complex transference feelings. With these patients the process was mostly cognitive, but did focus on the triangles of conflict and person. The main benefits of this approach would appear to be improved self-awareness and other non-specific benefits of therapy without actual emotional experience. These 16 patients had a mean of 15.1 sessions. All of these patients were highly resistant or fragile.

From Table 6a we see that each patient group reported significant symptomatic improvement. Only 50% of group 2 and 3 were able to return to work and less than half of them were able to

stop all medications during the course of therapy. The overall magnitude of improvements, including functional improvements, favors group 1.

Table 6b shows all the groups had cost savings or were revenue neutral in each category. The overall cost offset data does indicate an advantage to the first group, but even the third group had substantial savings overall.

Regarding hospital days, group 3 was the biggest cost saver, having had a major reduction in hospital days per patient in the follow-up year. Group 3 had the highest rate of hospital days the ear before therapy compared to groups 1 and 2: this accounts for the major cost reduction the year after therapy.

These findings suggest therapeutic efforts were financially beneficial in each group, including the patients I felt were not deriving the specific benefits of emotional experience in ISTDP. These findings match the literature supporting the cost benefits of a range of psychotherapeutic modalities that may or may not focus on emotional experiences. (10)

Table 6a: Outcome by Therapy Events: Self Reports and Functional Improvements: N=89

	Group 1 Unlockings	Group 2 Rise in CTF	Group 3 Low/ No Rise
N	57	16	16
Symptoms Improved to Normal (BSI) (N, p*)	56/57 $< 10^{-11}$	10/14 <.0001	4/10 <.01
Interpersonal Problems Improved to Normal (IIP) (N, p*)	44/49 $<10^{-5}$	7/13 <.05	1/2 n/a
Return to Work (N, %)	14/14 100%	2/3 67%	2/5 40%
Time to Return to Work (months)	3.1	1.4	2.2
Stopped all Medications (N, %)	25/27 92.6%	4/5 80%	2/11 18.2%
Time to Stop Medications (months)	2.4	1.7	1.5

* P values are 2 tailed Students t tests of pre versus post therapy scores.

Table 6b: Outcome by Therapy Events: Cost Data: N=89

	Group 1 Unlockings	Group 2 Rise in CTF	Group 3 Low/No Rise in CTF
Treatment Costs Per Patient	1793	1210	1661

(Canadian Dollars			
Decrease in Physician Costs Per Patient 1 Year Later (1)	236	36	67
Decrease in Hospital Costs Per Patient 1 Year Later (1)	195	0	1450
Decrease in Direct Disability Costs Per Patient 1 Year Later (2)	2657	256	1655
Decrease in Medication Costs Per Patient 1 Year Later (2)	2565	1791	465
Net Cost Offset Per Patient by 1 Year After Therapy (Saving Minus Treatment Costs)	3860	873	1986

1 Provided as aggregate groups of data by the Ministry of Health, British Columbia, Canada
2 Figures provided by Shoppers Drug Mart, Halifax, Canada

Other Observations: Reduction in Self Harm

Through out the treatment of this sample and samples since, I have been struck by how rapidly self harm behaviors stop. First, there were almost no (less than 5) emergency visits by any patient after starting the therapy. Second, only 1 patient required an admission to hospital during the course of therapy. Finally, I am not aware of a single suicide among any patient who had a trial of therapy in this time period and since then. This supports the contention that efforts to engage a patient and know him/her in depth, instills hope and motivation, and reduces self-destructiveness. This appears the case even when one is learning technique and trying to apply it. ISTDP is a very safe treatment because it trains a therapist how to monitor patients and to help them to battle self-destructiveness.

Discussion and Conclusion

Data from this early training sample suggest ISTDP is clinically effective, cost-effective and well tolerated. The findings corroborate Davanloo's concept of 2 treatment spectra. This data highlights the extreme breadth of patients who are candidates for a trial of ISTDP: no known therapy approaches this magnitude of applicability. Finally, it suggests that a trainee can use this approach and accrue benefits with the broad range of patients.

Low drop out rates suggest that the therapy was well tolerated, even when not effective in some cases. This does not match the experience of some of my colleagues who experience high drop out rates when starting to do ISTDP. I believe the early exposure to a bulk of training reduced the drop-out rate. The main problem leading to my and my colleagues drop outs appeared to be premature challenge and secondary misalliance. This will be the topic of a later paper.

A moderate amount of training allowed a beneficial treatment response, despite the fact that most patients were highly resistant. This response was reflected in every dimension assessed, including patient self-reports and health costs analysis.

The cost benefits revealed in this study are striking. Hospital, physician cost and disability cost savings more than offset the cost of therapy. Very few patients appeared to need medications when therapy was started, and most stopped all medications rapidly. One could argue that some of these patients improved because they were relieved of medication side effects! In our country, there appears to be significant over-prescribing, and this is reflected in this data.

This study allows us to discuss the benefits of having an office database. First, a database allows one to examine how patients are doing in therapy as a whole. Second, one could use this database to estimate how long therapy will be, and how likely therapy is to be helpful. This is useful information for patients or third party payers who will be paying for therapy. Finally, in this era of quality assurance and accountability, one could use this database to demonstrate the costs and benefits of one's work. Inevitably, from my review of ISTDP, this should lead to training program development and funding of research projects.

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References

1. Davanloo, H. (1995). "Intensive short-term dynamic psychotherapy: Spectrum of psychoneurotic disorders." International Journal of Short-Term Psychotherapy 10: 121-155.
2. Davanloo, H. (1990). The technique of unlocking the unconscious in patients suffering from functional disorders. Part I. Restructuring ego's defenses. Unlocking the unconscious. H. Davanloo. Chichester, England, John Wiley & Sons: 283-306.
3. Whittemore, J. (1996). "Paving the royal road: An overview of conceptual and technical features in the graded format of Davanloo's intensive short-term dynamic psychotherapy." International Journal of Short-Term Psychotherapy 11: 21-39.
4. Davanloo, H. (1986). "Intensive short-term dynamic psychotherapy with highly resistant patients. I. Handling resistance." International Journal of Short-Term Psychotherapy 1(2): 107-133.
5. Davanloo, H. (1986). "Intensive short-term dynamic psychotherapy with highly resistant patients. II. The course of an interview after initial breakthrough." International Journal of Short-Term Psychotherapy 1(4): 239-255.
6. Abbass, A (2000) " A Multicentre Controlled Trial of Short-term Dynamic Psychotherapy in Patients With Personality Disorders. Proceedings of the Canadian Psychiatric Association Annual meeting, Victoria BC, November 2000
7. Malan D. "The Most Important Development Since the Discovery of the Unconscious" in Short-term dynamic psychotherapy. Davanloo, H. (1980). New York, Jason Aronson.

8. Davanloo, H (1995) “Intensive Short-term Dynamic Psychotherapy: Technique of Partial and Major Unlocking of the Unconscious with a highly resistant patient. Part I Partial unlocking of the unconscious. International Journal of Short-Term Psychotherapy 10(3,4): 183-230.
9. Abbass, A (2002) “ Intensive Short-term Dynamic Psychotherapy in a private psychiatric office: clinical and cost effectiveness. American Journal of Psychotherapy 56(2): 225-232.
10. Lazar, S. and G. Gabbard (1997). “The cost-effectiveness of psychotherapy. Journal of Psychotherapy Practice and Research 6(4): 307-314