

Brief Report

INTENSIVE SHORT-TERM DYNAMIC PSYCHOTHERAPY OF TREATMENT-RESISTANT DEPRESSION: A PILOT STUDY

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This pilot study examined the effectiveness of Intensive Short-term Dynamic Psychotherapy (ISTDP) in treatment-resistant depression (TRD). Ten patients with TRD were provided a course of ISTDP. Clinician and patient symptom and interpersonal measures were completed every 4 weeks, at termination, and in follow-up. Medication, disability, and hospital costs were compared before and after treatment. After an average of 13.6 sessions of therapy, all mean measures reached the normal range, with effect sizes ranging from 0.87 to 3.3. Gains were maintained in follow-up assessments. Treatment costs were offset by cost reductions elsewhere in the system. This open study suggests that ISTDP may be effective with this challenging patient group. A randomized, controlled trial and qualitative research are warranted to evaluate this treatment further and to examine its possible therapeutic elements. Depression and Anxiety 23:449–452, 2006. © 2006 Wiley-Liss, Inc.

INTRODUCTION

Treatment-resistant depression (TRD) is a common, underresearched clinical problem that exacts a large burden on patients and on the health care system. Available evidence suggests that up to 50–60% of patients do not respond adequately to initial antidepressant trials [Fava, 2003]. Despite this, there is a noted absence of clinical trials to support specific pharmacotherapeutic augmentations [Nelson, 2003] or psychotherapies [Thase et al., 2001] in this challenging patient category. Thus, clinicians are left without evidence on which to base clinical decisions.

Comorbid personality disorders and problems managing emotions have been touted as explanations for poor treatment response in some patients with depression. Patients with personality disorders have defensive behaviors that can interrupt the treatment relationship [Thase, 2002]. Problems identifying emotions, alexithymia, was associated with the severity of residual depressive symptoms in one recent study [Ogrodniczuk et al., 2004]. Gilbert et al. [2004] found that over 80% of a sample of patients with depression directed anger at themselves. Theoretically, any of these psychological problems can counter the effects of clinical management if they are unattended.

Davanloo [1987] developed intensive short-term dynamic psychotherapy (ISTDP) to treat patients with depression and personality disorders through an emotion-focused process. This treatment helps the patient to overcome problems in regulating complex feelings, a process identified as important in diverse research [Gilbert et al., 2004; Ogrodniczuk et al., 2004]. In a randomized, controlled trial, ISTDP produced superior antidepressant effects to “a more cognitive” form of psychotherapy in symptomatic

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patients with personality disorders [Winston et al., 1991]. Recent meta-analyses found this and other brief dynamic therapy methods [Leichsenring et al., 2004] effective in treating general psychiatric symptoms and in adding significant benefits to medication alone in major depression [Pampallona et al., 2004].

This pilot study is the first to examine the feasibility and clinical effectiveness of this therapy in patients with TRD.

MATERIALS AND METHODS

A consecutive series of 10 adult psychiatrist-referred outpatients with a primary diagnosis of TRD were invited to participate in an uncontrolled trial (Table 1). The study was approved by the hospital ethics board, and all participants gave written informed consent. TRD was defined as inadequate response to two adequate dose/adequate duration antidepressants from two different antidepressant classes. All patients were diagnosed with TRD by the referring psychiatrist and clinical assessment in the intake interview. Axis II diagnoses were also derived through assessment interviews.

TABLE 1. Demographic and baseline characteristics

	All patients (<i>N</i> = 10)
Age (years)	
Mean \pm S.D.	49.7 \pm 8.7
Min, max	37, 63
Gender, <i>n</i> (%)	
Female	7 (70)
Male	3 (30)
Race <i>n</i> (%)	
Caucasian	10 (100)
Employment status <i>n</i> (%)	
Employed full-time	2 (20)
Employed part-time	1 (10)
Disabled	5 (50)
Retired	2 (20)
Medications in use <i>n</i>	
Selective serotonin reuptake inhibitor	9
Selective norepinephrine reuptake inhibitor	3
Tricyclic antidepressant	1
Atypical antipsychotics	3
Benzodiazepines	4
Tryptophan	2
Pindolol	1
Thyroxine	1
Zopiclone	1
Childhood abuse history <i>n</i> (%)	
Emotional abuse	10 (100)
Physical abuse	6 (60)
Sexual abuse	1 (10)
Predominant personality disorder diagnosis <i>n</i> (%)	
Avoidant	5 (50)
Borderline	3 (30)
Dependent	1 (10)
Schizoid	1 (10)

Patient self-report measures included the Brief Symptom Inventory—Depression subscale [BSI-D; Derogatis and Melisaratos, 1983] and the Inventory of Interpersonal Problems [IIP; Horowitz et al., 1988]. The 17-item Hamilton Rating Scale for Depression (HAM-D-17) and the Clinical Global Index—Severity scale (CGI-S) served as clinician ratings. Each of the measures was recorded every 4 weeks during treatment and at termination. Hospital fees, disability costs, and medication costs were compared from 1 year before therapy to 6 months after therapy. Prescription costs were provided by a local pharmacy.

The treatment process began with assessment of the patient's capacity to respond to emotionally focused interviewing. From this assessment, the process became either more emotionally focused or more cognitive, with the aim to increase capacity to tolerate emotions. When the patient had developed the capacity to tolerate emotions, emotions about recent and past emotion-laden events were focused upon to help the patient experience these emotions directly. Each such focus was followed by recapitulation of what was learned, to encourage emotional awareness and weaken the patient's avoidance of emotional experiences. Thus, the process helped build tolerance of emotions and development of insight into emotions and their impact on mood states. It also provided a healing and corrective experience by addressing in an atmosphere of validation and support, patients' emotions about recent and past trauma [Davanloo, 1987].

Pre- versus post-BSI-D, -IIP, -HAM-D, and -CGI ratings were compared with paired *t*-tests. Subscales of the IIP were analyzed and compared by paired *t*-tests. Total cost data were calculated for comparison.

RESULTS

The sample comprised mainly a disabled and chronically ill group of patients. Five were disabled from work for an average of 101 weeks (range, 4–130) prior to therapy. They were taking a total of 25 psychotropic medications. All had comorbid personality disorders and histories of childhood abuse. All had received previous psychotherapy, including cognitive therapy, day program, group therapy, and supportive therapy. Five had past psychiatric hospitalizations, and two patients had each undergone two previous courses of electroconvulsive therapy (ECT).

The initial mean Ham-D-17 rating was 22.6 (range, 13–31, *SD* = 5.9) and CGI rating was 5.6 (range, 2–7, *SD* = 1.3), suggesting marked illness levels on average. All were outside of the normal range for the BSI-D, suggesting significant depressive symptoms. All but two patients were outside of IIP norms, suggesting major interpersonal problems (Table 2). Treatment averaged 13.6 (*SD* = 6.3, range, 6–25) sessions.

Eight patients remitted, with HAM-D-17 ratings under 8. The remaining two patients went from scores of 31 to 12, and 27 to 14, respectively, so, in total, 9 of

TABLE 2. Main outcome measures

Measure	Pretherapy <i>M</i> (<i>SD</i>)	Posttherapy <i>M</i> (<i>SD</i>)	Follow-up <i>M</i> (<i>SD</i>)	Effect size pre vs. post (Cohen's <i>d</i>)	Effect size pre vs. follow-up (Cohen's <i>d</i>)
HAM-D	22.6 (5.9)	6.0 (3.8)***	6.6 (3.9)***	3.39	3.27
CGI	5.6 (1.26)	3.4 (1.3)***	2.1 (0.98)***	1.72	3.12
BSI-D	2.8 (0.82)	0.9 (0.69)***	1.1 (0.96)**	2.52	1.91
IIP	1.54 (0.32)	1.05 (0.57)*	0.91 (0.35)**	0.87	1.88

* $P < .05$, ** $P < .01$, and *** $P < .001$ compared to pretherapy using pairwise, two-tailed *t*-tests.

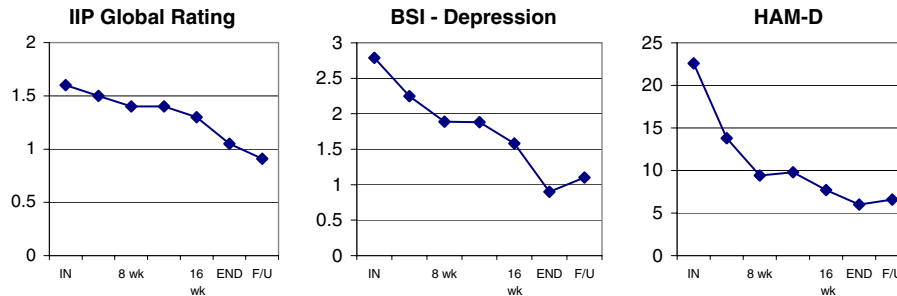


Figure 1. Mean score of self-reported inventories and clinician rating.

10 patients met criteria for response. Mean CGI-S ratings dropped by 2.15 points. Mean BSI-D scores went from above to within the standard normal range. Mean Global IIP ratings went from significantly above the normal average to within the normal range. Patient reports paralleled clinician ratings in time and overall magnitude of improvements. In follow-up averaging 6.1 ($SD = 5.8$) months, these gains were held on each measure, with no statistical difference between post-therapy and follow-up. Effects sizes for each measure were large (>0.80) and maintained in follow-up (Table 2, Figure 1).

Interpersonal problem ratings improved in parallel to depression ratings. The Nonassertive, Socially Inhibited, Self-Sacrificing, and Overly Accommodating subscales all showed significant improvements (all P s $< .05$). The Domineering and Cold/Distant subscales showed trends toward significant improvement (P s $< .10$).

During this study, the group stopped 14 medications, including serotonin reuptake inhibitors (SRIs; 6), venlafaxine (1), and augmentation agents (6). Five medication doses were decreased and none were increased. One patient stopped taking three medications and was started on tranylcypromine 10 mg/day per a previously planned substitution. Three participants required no medications by termination.

Four patients were able to return to full-time work from disability, whereas one went from part- to full-time work. One patient who had missed over 20 workdays in the previous 6 months reported an absence of missed days. Another patient returned to full-time university attendance. Another patient retained a disabled state due to osteoarthritis pain and depressed mood.

In the follow-up period, two patients experienced a transient return of depressive symptoms. These patients had had short courses of therapy (six and eight sessions, respectively) and were the only patients not to reach the normal cutoff for the IIP. Both were female, ages 60 and 63, and had achieved symptomatic relief to a level they felt was adequate enough to terminate treatment. Both had been in the mental health system for many years, had avoidant personality disorder, and were reluctant to engage in psychotherapy, rendering their treatment courses partial in effect and duration. Neither patient required any further therapy by the time of the follow-up meeting: One had an increase in dose of antidepressant to the pretherapy level and the other had improved spontaneously.

Six months poststudy compared to 6 months prestudy, the group's total costs for medication, disability, and hospitalization were reduced by \$8,880, \$33,600, and \$14,400 (Canadian dollars), respectively.

DISCUSSION

This study has the limitations of a small, single-therapist, uncontrolled study. Coincidental improvements cannot be ruled out with this design, although long histories of depression, nonresponse to previous psychotherapy efforts, and the short treatment period makes random chance a less likely cause of the gains. The therapist was an experienced practitioner of this therapy, so results may not be repeatable with less experienced therapists. Finally, there were no blinded outcome ratings in this pilot study, although patient and clinician reports paralleled each other in magnitude over time.

This sample of resistant patients made substantial functional and symptomatic gains during this course of brief therapy. Using HAM-D-17 criteria, 9 out of 10 patients responded, whereas 8 remitted with an average of 3 months of treatment. Patients were able to return to work despite long disabilities, a finding observed in previous treated samples [Abbass, 2002]. These findings corroborate other research showing that this and other specific psychotherapy methods add significantly to the effects of antidepressant medications [Pampallona et al., 2004].

The observation that depression and interpersonal problems improved simultaneously suggests that personality changes may be necessary in TRD for depression to lift. The lack of normalization of IIP in the two patients who returned with symptoms further supports this notion. In patients with personality disorders [Kool et al., 2003] or histories of trauma [Nemeroff et al., 2003], addressing emotional and personality factors appears important, if not necessary, in order to bring adequate treatment response. These findings also suggest that IIP and similar measures may serve as markers of beneficial response and of relapse risk for this group of patients. The relapse noted in the shortest courses of therapy suggests that 12 sessions may be a minimum treatment required to solidify gains in most cases.

Treatment costs were offset soon after initiation of therapy. System cost reductions further demonstrate this treatment's cost-effectiveness [Abbass, 2003]. Given the major expense of TRD [Crown et al., 2002], third-party payers may consider providing these types of treatment, if for no other reason than cost containment.

Thus, ISTDP appears overall to be feasible, cost-effective, and beneficial in this uncontrolled case series of treatment-resistant patients. This treatment warrants further study in TRD, including a randomized, controlled trial and treatment factor analysis from session videotapes. Such microanalysis of specific therapy elements may add to existing research about important or essential ingredients in the psychotherapy of this challenging population.

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REFERENCES

- Abbass AA. 2002. Intensive short-term dynamic psychotherapy in a private psychiatric office: Clinical and cost effectiveness. *Am J Psychother* 56:225–232.
- Abbass A. 2003. The cost-effectiveness of short-term dynamic psychotherapy. *Expert Rev Pharmacoeconomics Outcomes Res* 3: 535–539.
- Crown WH, Berndt ER, Ling D, Poret AW, Rush AJ, Russell JM. 2002. The impact of treatment resistant depression on health care utilization and costs. *J Clin Psychiatry* 63:963–971.
- Davanloo H. 1987. Intensive short-term dynamic psychotherapy with highly resistant depressed patients: Part I. Restructuring ego's regressive defenses. *Int J Short-Term Psychother* 2:99–132.
- Derogatis L, Melisaratos N. 1983. The brief symptom inventory: An introductory report. *Psychol Med* 13:595–605.
- Fava M. 2003. Diagnosis and definition of treatment-resistant depression. *Biol Psychiatry* 53:649–659.
- Gilbert P, Gilbert J, Irons C. 2004. Life events, entrapments and arrested anger in depression. *J Affect Disord* 79:143–149.
- Horowitz LM, Rosenberg SE, Baer BA, Ureno G, Villasenor VS. 1988. Inventory of Interpersonal Problems: Psychometric properties and clinical applications. *J Consult Clin Psychol* 56:885–892.
- Kool S, Duijsens I, de Jonghe F, Puite B. 2003. Efficacy of combined therapy and pharmacotherapy for depressed patients with or without personality disorders. *Harvard Rev Psychiatry* 11:133–141.
- Leichsenring F, Rabung S, Leibing E. 2004. The efficacy of short-term psychodynamic psychotherapy in specific psychiatric disorders: A meta-analysis. *Arch Gen Psychiatry* 61:1208–1216.
- Nelson JC. 2003. Managing treatment resistant depression. *J Clin Psychiatry* 64(Suppl 1):5–12.
- Nemeroff CB, Heim CM, Thase ME, Klein DN, Rush JA, Schatzberg AF, Ninan PT, McCullough JP Jr., Weiss PM, Dunner DL, Rothbaum BO, Kornstein S, Keitner G, Keller MB. 2003. Differential responses to psychotherapy versus pharmacotherapy in patients with chronic forms of major depression and childhood trauma. *Proc Natl Acad Sci USA* 100:14293–14296.
- Ogrodniczuk JS, Piper WE, Joyce AS. 2004. Alexithymia as a predictor of residual symptoms in depressed patients who respond to short-term psychotherapy. *Am J Psychother* 58:150–161.
- Pampallona S, Bollini P, Tibaldi G. 2004. Combined pharmacotherapy and psychological treatment for depression: A systematic review. *Arch Gen Psychiatry* 61:714–719.
- Thase M, Friedman ES, Howland RH. 2001. Management of treatment resistant depression: Psychotherapeutic perspectives. *J Clin Psychiatry* 62(Suppl 18):18–24.
- Thase M. 2002. The role of Axis II comorbidity in the management of patients with treatment-resistant depression. *Psychiatr Clin North Am* 19:287–309.
- Winston A, Pollack J, McCullough L, Flegenheimer W, Kestenbaum R, Trujillo M. 1991. Brief psychotherapy of personality disorders. *J Nerv Ment Dis* 179:188–193.