ISTDP AND ELECTRO-CONVULSIVE THERAPY

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Summary

In this article, we review Intensive Short-Term Dynamic Psychotherapy (ISTDP) as an alternative to electroconvulsive therapy (ECT) or as treatment for patients not responding to ECT. Based on our clinical observations, we conclude that ISTDP can be used as a preventive treatment in selected patients. Furthermore, failure to respond to ECT may suggest that psychotherapeutic issues are prominent and predict response to ISTDP. We conclude with clinical and research recommendations.

Background

ECT is a commonly used treatment in psychiatry, its major indication being for major depressive disorders, especially with psychotic features or in the elderly. It is generally offered in inpatient settings, though outpatient treatment is sometimes also offered (Sadock and Sadock, 2003).

When developed in the early 20th century ECT could have been viewed as a relatively benign intervention in comparison with other psychiatric treatments of the day which included such interventions as insulin shock therapy, hydrotherapy, and later prefrontal lobotomy. It became more benign with the advent of modern techniques of delivery. Nevertheless, over the years it's utilization has been limited by the fact that it is still an invasive procedure with significant side-effects. While major procedural complications including death are decidedly rare, post-procedure confusion and short to long-term complaints regarding memory are common. Despite this subjective complaint however, most studies demonstrate return to baseline memory within 6 months and neuro-imaging studies failed to detect objective brain damage related to ECT. Procedural complications such as headache, backache and myalgias are common, while broken teeth are an uncommon occurrence (Sadock and Sadock, 2003).

Despite these side-effects and significant public misgivings, there has been an increase in the use of ECT. It is recently estimated that it is provided to 100,000 patients per year in the USA. This is doubtless related to the fact that it is widely considered by many psychiatrists as the most effective treatment for a range of depressed patients who have not responded to pharmacological intervention. Further, psychotherapies are often not considered for these severely disordered patients (Sadock and Sadock, 2003).

This utilization is not out of keeping with current depression treatment guidelines. One recently published set of practice guidelines suggests a "PACE" approach (Malhi et al., 2009). "P" stands for Psychological therapies, noting equal efficacy where the depression is not severe and in absence of psychotic features: The authors report that evidence supports cognitive behavioral therapies and short-term psychodynamic therapies, among other modalities, in the acute phase. Thereafter, they suggest to consider "A", Antidepressants, followed by "C", a Combination of medication and psychotherapy, before finally considering

"E", for ECT. We are encouraged that the guidelines suggest consideration of talk therapies first. However, given the caveats regarding severe depression or depression with psychotic features, one could interpret that ECT would be a reasonable consideration ahead of psychotherapy in these circumstances.

Intensive Short-Term Dynamic Psychotherapy

In our Centre, affiliated with a major Canadian teaching hospital, we practice Davanloo's Intensive Short-Term Dynamic Psychotherapy model (ISTDP, Davanloo, 2001). This therapy focuses on removing a patient's resistances to expose the core emotional underpinnings of their psychiatric difficulties. This treatment entails the experience of conflicting feelings which typically date back to the early parts of the patient's life as result of attachment trauma. These feelings are manifested in the patient's current life's sphere as well as in the psychotherapeutic context and typically include unconscious rage, guilt and grief over broken attachments. The concepts of the triangles of person and of conflict, well known to dynamic therapists, are often used to illustrate these ideas. The triangle of person depicts how unconscious feelings from the past are transferred to current relationships, as well as to the therapeutic relationship. The triangle of conflict represents how unacceptable or painful unconscious feelings generate unconscious anxiety which in turn fuels unconscious defense mechanisms: these defenses and anxieties manifest as psychiatric complaints, characterological problems and resistance to emotional closeness.

ISTDP has a broad evidence base regarding patients at risk for hospitalization and ECT. It has been shown effective with patients with personality disorders plus treatment resistant depression, including in patients who had previous ECT (Abbass, 2006). It is efficacious in patients with personality disorders (PD) now with 3 randomized controlled trials (RCT) (Winston, 1994, Hellerstein et al, 1998, Abbass et al, 2008). It has also been shown to reduce hospitalization, physician use, medication use and disability (Abbass, 2002, 2003). ISTDP has been utilized with excellent effect in an inpatient residential facility with primarily personality disordered patients (Cornelissen and Verheul, 2002). Case series and case data show the model can be applied in select patients with schizophrenia (Abbass, 2001) and bipolar disorder (Abbass, 2002b). The trial therapy model of assessment (Said, 1990) has been shown to be a potent symptom reducing treatment-assessment, outperforming standard psychiatric assessments and bringing significant symptom reduction in 1 month follow-up (Abbass et al, 2008b, 2009). ISTDP is among other brief dynamic treatments demonstrated effective in the treatment of major depression in a recent meta-analysis (Driessen et al, in press).

Our Centre has collected a case series of patients referred to us by inpatient services who were being considered for, receiving, or had received but not adequately responded to ECT treatment. Our examination of this population indicates the following:

1 Patients referred to us have all failed to adequately respond to medications and a range of psychotherapy efforts.

2 These patients generally have experienced some rupture or threatened rupture to important relationships in the current life sphere. This rupture mobilizes complex feelings of pain, rage, guilt, and grief within the patient which are commonly rooted in major attachment trauma from the patient's early life.

3 The patients present with high anxiety, somatization, conversion, depression, or cognitive-perceptual disruption.

4 The ISTDP trial therapy model can be an excellent tool to assess psychological capacities, to increase anxiety tolerance, and to bring symptomatic reduction in these patients.

5 ISTDP is a short-term therapy which in our Centre involves an average of 3-6 sessions when used with inpatients.

6 Nearly all patients we assess with the ISTDP Trial Therapy before ECT do not need it after the assessment process.

7 Many patients are able to reduce or stop medications when provided with this treatment.

8 Discharge from hospital is accelerated and re-hospitalization is rare in followed up cases.

To illustrate the finding of reduced hospitalization rates, we examined data extracted from a 2006 quality assurance study. In all the 63 patients who had at least 7 hospital days in the year before ISTDP-treatment, we observed a sustained 90.7 % reduction in hospital use. They went from an average of 38.1 (SD 52.9) hospital days before to 3.6 (SD 11, p <0.0001) hospital days per patient per year after ISTDP treatment. These data include virtually all inpatients who had ECT before being sent for our treatment.

Case Illustrations

In order to illuminate these findings, we herein present several brief patient vignettes:

Case 1

This 73 year old male patient with depression with psychotic features had 30 ECT treatments while in hospital during the prior 4 months. He had failed to respond to a series of medications and ECT and continued to be severely depressed. He arrived to the 90-minute trial therapy session hobbled over clutching his side with some discomfort. He was mumbling in a vague fashion about his work background and how he had pain in his side for some years. The pain had produced severe depression and suicidal ideation. He was agitated, depressive, with downcast mood but also was anxious. He was tense and had some tendency toward hand clenching and sighing respirations.

We focused in the room on some of the underlying feelings that were generating this tension. With this focus there was a rise in complex transference feelings and he began to focus away from his side and started to detach and defend in the room, putting a wall between himself and the therapist. We focused on the underlying feelings and interrupted his defenses against engagement. He became less and less focused on his physical pain.

With this focus there was a passage of some complex emotions in the transference with irritation and a positive feeling towards the therapist. With this experience there was a drop in tension and improvement of eye contact. He went on to describe a specific situation which he had in the past with his father, where his father was quite critical with his mother and in fact struck her. He was approximately 5 years old. He was full of anger but adapted quite a helpless and frozen position. As he began to speak about this there was an increase in symptoms of tension and distress in his right side. We focused on his underlying anger towards his father and there was a further rise in complex transference feelings. With a high degree of pressure and challenge he was actually able to experience a violent feeling towards his father with an urge to stab him with a kitchen knife that was nearby. In doing so he felt a powerful physical energy from his abdomen upwards. This was followed very closely however with a feeling of shock and guilt for wanting to damage the father. The father was clutching his abdomen and terrified of his son.

We focused at the end of this interview on some ways of understanding his symptoms. He had chronically been a frozen, anxious, depressive person who had become increasingly obsessed and detached. A lot of strong feelings were being stirred up with his wife when he retired from work and from his viewpoint she became more ”bossy”, directing his daily activities. The boss at work seemed to have the same characteristics as his father and his wife in turn. All these feelings were being mobilized but the patient unconsciously converted them into depression, anxiety and rumination about his body. We also saw that some of the pain in his side may have been from striated muscle tension and otherwise it was sympathetic pain for what his rage would have done to his father.

At the end of the interview he noted having an absence of anxiety. When asked about how his side felt he noted that there he had absolutely no symptoms left!

When followed up again two weeks later he had noted only a few moments when there was any discomfort in his side. All of his symptoms had undergone a major reduction with a single trial therapy. His mood was brighter and he was making plans for the future. We had four further one-hour treatment sessions where he made further gains and discharge planning was commenced.

From this case we noted that elderly depressed patients may respond well to ISTDP, that having recent ECT doesn’t necessarily interrupt treatment response in each case and that rapid symptom reduction can be possible in medium to long stay patients.

Case 2

This 32 year old divorced mother of one presented to our two-hour trial therapy session with persistent “auditory and visual hallucinations”, agitation and irritability. She had continual intruding nightmares and day time images of being murdered or someone trying to murder her daughter. Her symptoms had all worsened in relation to ongoing marital discord and interactional difficulties with her mother. In addition she had a history of head injury. She had been diagnosed with ADHD, generalized anxiety, psychosis NOS among other diagnoses. She was being considered for ECT.

In the trial therapy interview she came in with unconscious anxiety in the form of muscular tension but also defending against engagement with the therapist. She appeared agitated. We

first examined her anxiety to reduce the overall level of anxiety and to acquaint her with the manifestations of this anxiety. The therapist acquainted her with the various ways she detached and avoided engagement with the therapist. From this there was a rise in complex transference feelings. This led to a partial passage of complex feelings towards her former husband which became clearly linked to her mother in the past. This brought about a significant reduction of tension. She had never before been aware of these complex emotions and transferences.

We could not make a firm conclusion about the origin of the images and nightmares she was experiencing. She did however relate that at the age of 10 months her parents separated and she never again saw her father. We concluded that is was possible that her feelings about the separation she was facing were very likely to mobilize feelings from her infancy when her parents separated. These emotions could result in projective processes, cognitive disruption and high anxiety.

She experienced a significant drop in depression, agitation and anxiety from this single session. She was able to be discharged after the first meeting and she had 3 further one-hour sessions. We concluded that her main problem was that of generalized anxiety disorder rather than a psychotic disorder. There was a reduction in her irritability, restlessness and tension, countering the notion that she had some neurological process or ADHD or head injury causing her difficulties. She was able to stop taking benzodiazepine at the end of this process.

This case underscores our finding that many patients who appear to have severe psychiatric disorders, actually have psychoneurotic disorders or fragile character structure.

Case 3

This was a 45 year old single woman with a chronic history of emotional detachment, high anxiety, depression and hopelessness. She also had a significant history of psoriasis and a tendency to bite her lip and nails. She had a chronic generalized avoidant pattern. She was being considered for ECT due to delayed response to inpatient care. She had been on a number of medications including antipsychotic, antidepressant benzodiazepines. She had multiple investigations including neurological assessments, CT scan and EEG without any specific biological abnormality detected.

In the 90-minute trial therapy we focused on the anxiety she came in with. With a focus on the underlying emotions we saw that there was a threshold at which she became quite flat and depressive. We thus worked in a graded fashion to build up her capacity to tolerate anxiety and to mobilize the unconscious complex feelings and therapeutic alliance.

With this mobilization she was able to see how detached she was and she experienced some empathic grief for herself for being so emotionally disconnected throughout her life. From there she went directly to an incident when she was age 6 when she had developed symptoms referable to Tourette's Syndrome. Her family members were actually blaming her for developing these symptoms, saying she had made up the symptoms. This brought about a lot of painful feelings but also reactive rage and guilt about the rage which she was able to experience in this interview. This brought about a complete resolution of anxiety within this interview. We also noted there was significant reduction of redness in her psoriatic lesions by

the end of the interview. We concluded this to be a direct vascular effect due to a reduction in anxiety.

In follow-up one-hour interviews she was able to further access and experience underlying complex feelings and gain a deeper understanding of the specific triggers which led her to admission. In the second session, for example, she came in with a projective concept that the therapist would be critical or judge her. We examined this and focused on underlying feelings which brought a rise in complex transference feelings. This mobilized grief about her being so detached and afraid for so many years. This became linked to painful feelings in relationship to her father being critical and abrupt with her. This painful feeling became linked to another incident in which she had intense rage and guilt about the rage towards her father. This became linked to grief about her mother's death and how that impacted her father. The mother's death some months prior to hospitalization appears to have been a trigger for all these emotions. There was further grief about the fact that the family had become disjointed since the mother's death.

She made excellent gains over these 2 sessions and was able to be discharged from hospital. She has had no further hospitalizations now, 1 year later. We concluded she had some degree of fragile character structure and also significant repression with depressive tendencies. These problems responded well to the ISTDP model using the graded format to build capacity.

Case 4

This 59 year old married woman came in the first interview unable to speak, mute with rapid eye blinking, overwhelmed with cognitive perceptual disruption and hallucination. Her working diagnosis was a brief psychotic episode with symptoms that had come on over a month related to workplace stress and finding out her husband was having an affair. In this first interview we were unable to perform any type of evaluation apart from explaining to her that medication management was required for her first prior to attempting psychotherapy. At the beginning of the referral she was already scheduled for electroconvulsive therapy.

She was treated with antipsychotic medication for a further 4 days. She came in the next one-hour session and had major anxiety about engaging in the interview. She had a very low threshold above which she would experience cognitive perceptual disruption, projection and hallucination. We worked to acquaint her with the link between feelings, anxiety and defenses, the physiology of her anxiety, the content of projection and how past and present emotional process had parallels with each other. This work produced a gradual rise in complex feelings. By the end of this interview she was curious to have further interviews. She responded to each session with further rise in capacity to tolerate anxiety. At the same time antipsychotic medication had been instituted and was likely taking effect. By the fourth session she was able to experience a moderate rise in complex feelings and had a passage of grief, after a split second passage of somatic pathway of rage. We saw that she had come from quite a disorganized background with a mother who may have had schizophrenia. She became more solid and strong over 4 one-hour sessions which took place over two and half weeks and she was discharged in under three weeks.

We concluded based on her early response after the second session that ECT was not necessary and she never did require ECT. She went from hospital to attend the day hospital program and was doing very well in a brief follow up 1 month later.

Case 5

This 40 year old women was admitted to acute inpatient services with suicidal impulses in the context of major interpersonal discord with her young adult daughter. She was brought to hospital from a bridge after she had emailed her psychiatrist that she was suicidal. Initial diagnoses included major depression, dysthymia, social phobia as well as cluster B traits. Inpatient staff were considering ECT treatment but also requested a psychodynamic assessment.

Initially the patient presented in the 3-hour trial therapy as very depressed with some catatonic features, very poor eye contact and major anxiety which took the form of compulsively tearing at a tissue throughout the interview. In the early sessions we were able to intellectually examine how she would turn anger onto herself, especially in relation to her daughter. The patient had a traumatic upbringing, with a father who left home when she was very young, and a mother not "fit to raise a dog" in the patient's estimate. She developed a tendency towards melancholy in which she would withdraw from the world: in this context her daughter at a young age was badly sexually abused while the patient was "asleep at the wheel" with depression. Thus, when the daughter grew older and began to manifest major behavioral disturbances of her own, the patient found it impossible to be angry with her, the anger being directed toward herself instead.

In a second two-hour interview the patient had a small breakthrough of visceral anger with the daughter, with concomitant painful guilt. In a later interview she had a major unlocking in the transference which to her surprise linked to the eyes of her father with whom she had barely had a relationship: she realized at this point that she had never lost the urge to be close to her father. A subsequent major unlocking linked to the eyes of the daughter accompanied by major guilt and grief. Amongst other positive changes noted by the patient, she described that subsequent to her experience of rage and guilt she was beginning to experience also love for her daughter. Inpatient staff concomitantly noted a positive change in the patient's state, and she was discharged without ECT or further pharmacological changes, but with outpatient psychotherapeutic follow-up. At the time of this writing she is currently in treatment and making steady gains after eight 90-minute sessions.

This patient gradually developed psychological mindedness and came to feel that the themes identified in the therapy were towards the heart of her psychiatric difficulties. She began to feel hopeful that she could overcome these difficulties.

Discussion

Based upon our clinical experience with these and other patients over recent years who either had ECT or were being considered for it, it is our conclusion that a trial of ISTDP is warranted prior to consideration of ECT even in cases with severe or psychotic features. We base this upon the fact that only one patient out of our sample went on to require ECT after ISTDP. We similarly believe that consideration should be given to a trial of therapy prior to institution of long term medications.

Further benefits aside from avoided ECT were noted. Many of these patients were able to reduce medications and stop them in follow-up sessions. The treatment was brief and relatively inexpensive and could easily be added to inpatient care. While patients with psychoneuroses are often seen in a negative light due to self hatred, self harm and undermining of treatment, this therapy seemed to help improve relationships with some of these patients, likely adding to benefits from the care provided by inpatient staff. The shortening of hospital stays which we have observed is very important in our very constrained Canadian medical system.

There were no problems observed from providing this treatment. Generally good communication between therapists and inpatient staff seemed to minimize splitting within the patient or among caregivers. One breakdown in communication did lead to a patient receiving ECT despite significant clinical improvements, thus highlighting the need for clear and regular communication. In our experience it was helpful that most of the referring physicians had some training or exposure to the ISTDP model. It is quite possible that their familiarity with the model allowed them to select patients most likely to benefit from this treatment model.

Perhaps most significantly, the patients' conceptualization of their difficulties shifted markedly: They went from feeling at the mercy of poorly understood biological forces to believe they were experiencing understandable and reparable emotional processes. Thus, the locus of control in these people shifted towards the internal, thereby empowering them and inculcating genuine hope.

Conclusion

Where available, ISTDP, starting with a powerful trial therapy model, should be considered before prescribing ECT or medications. This treatment can be combined with standard inpatient care and may improve overall outcomes in the short and long term. It appears to minimize the need for ECT and allows lower medication doses in many patients. It is our belief that this is in keeping with our first imperative as physicians: "first do no harm". It appears also to reduce hospitalization, and thus it is cost effective.

Although it is possible that other psychotherapeutic methods may also be effective in reducing the need for ECT, our experience with this sample suggests ISTDP demonstrates this benefit. ISTDP warrants further study to determine if its effects add significantly to standard clinical care and to determine which populations may best benefit. At the time of this publication, planning is underway for either a randomized control trial or a naturalistic study of ISTDP for all inpatients having non psychotic disorders to see if it impacts on hospitalization, medication and ECT rates in the short and long-term.

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