

Journal of Addictive Diseases

ISSN: 1055-0887 (Print) 1545-0848 (Online) Journal homepage: https://www.tandfonline.com/loi/wjad20

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To cite this article: Jon Frederickson MSW, Bonnie DenDooven LPC, Allan Abbass MD, Ole Andre Solbakken PhD & Tony Rousmaniere PhD (2019): Pilot study: An inpatient drug rehabilitation program based on intensive short-term dynamic psychotherapy, Journal of Addictive Diseases

To link to this article: https://doi.org/10.1080/10550887.2019.1658513

Published online: 11 Sep 2019.

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JOURNAL OF ADDICTIVE DISEASES
https://doi.org/10.1080/10550887.2019.1658513

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Pilot study: An inpatient drug rehabilitation program based on intensive short-term dynamic psychotherapy

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ABSTRACT

Addiction programs are plagued with high dropout and relapse rates. A large proportion of patients suffering from addiction also suffer from personality disorders. A 30-day inpatient program based on intensive short-term dynamic psychotherapy was developed to address features of personality disorders such as anxiety regulation, emotion recognition, and handling of fear responses and projective processes. The hypothesis was that addressing comorbid symptoms of personality disorder might improve recovery from drug addiction. We used a pilot randomized controlled trial design with six-month follow-up of both cases and controls. Rates of remission, relapse and drop out were recorded at each time point. N-1 chi-squared (χ^2) tests were conducted to examine the statistical significance of differences in outcomes in patients receiving the experimental treatment and controls. A control group of 20 patients and an experimental group of 42 patients were treated. Dropout: control group 40%; experimental group 23.8%. Sobriety at six months: control group 17.6%, experimental group 48.8%. Future study is warranted to examine intensive short-term dynamic psychotherapy's long-term effects, study moderators of effects, and study its efficacy using a randomized controlled design.

KEYWORDS

Addiction; relapse; personality disorder; psychotherapy; anxiety

Introduction

Dropout rates range from 21.5 to 43%[1] in detoxification,[2] 23–50%[3] in outpatient treatment,[4] 17–57%[5] in inpatient treatment,[6] and 32–67.7% in substitution treatment.[7] 91% of heroin users relapsed after a six-week treatment program, 59% within the first wee.[8] Following treatment, 78.2% of heroin users, 68.4% of alcoholics, and 61.9% of cocaine users relapse[9] (Johnson 2014). "For 1-year outcomes across alcohol, nicotine, weight, and illicit drug abuse, studies show that more than 85% of individuals relapse and return to drug use within 1 year of treatment."[10]

Both treatment and patient factors have been implicated in treatment dropout rates.[11] Brorson et al.[12] found that the most consistent patient risk factors for drop out were cognitive deficits, low treatment alliance, personality disorder, and younger age. Low alliance emerged as a promising predictor of dropout. However, McKellar et al.[13] found that high-risk patients (e.g., younger, cognitive deficits) were less likely to drop out when they experience treatment as high in support and low in control. Baldwin et al.[14] demonstrated that outcome varies with individual therapists suggesting that therapists should attend to their contributions rather than on patient characteristics to improve the alliance.

Personality disorders are commonly diagnosed in individuals with alcohol use disorders and clients with drug addiction. In one inpatient drug treatment facility, "78% of the alcoholic patients had at least one personality disorder and the average number of personality disorders was 1.8 per patient. In the polydrug group, 91% of the patients met criteria for at least one personality disorder and the average number of personality disorders was 4.0 per patient."[10] In a national sample, 47% of clients with drug addiction had a personality disorder.[15]

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Clients with drug addiction and personality disorders may project their feelings and impulses onto others.[16] Once they project onto fellow patients and clinicians, they will defy, act out, or attack the projections they place upon others. The more they project in treatment, the more they act out, drop out, and relapse.

Psychotherapy that treats the defenses and cognitive weaknesses in personality disorders that can lead to misalliance improves outcome in drug rehabilitation. Woody et al.[17] found that those addicted to opioids who received short-term dynamic psychotherapy made more changes to a greater degree than those who received no psychological counseling in addition to rehabilitation and addiction counseling. Many of the gains from drug counseling dropped after six months, whereas, the gains from short-term dynamic psychotherapy maintained and even improved in six month follow up. Carroll et al.[18] found that short-term dynamic psychotherapy could be effective with cocaine users, and the effects grew over one year follow up.[19] Also, psychotherapy plus pharmacotherapy can enhance and extend outcomes for many substance abuse disorders.[20]

Over the past 25 years, intensive short-term dynamic psychotherapy (ISTDP), has emerged as an effective treatment[21] for complex patients with personality disorders,[22] low anxiety tolerance, and mixed psychiatric symptoms.[23] ISTDP has developed methods to build emotional capacities, handle defenses,[24] and facilitate healing emotional experiences to address underlying attachment trauma.[25] The treatment requires videorecording based supervision to facilitate self awareness and build capacity in therapists.[26,27]

Solbakken and Abbass[11] and Cornelissen and Verhuel[28] reported on long-term follow-up for ISTDP residential treatment progams for highly refractory patients with personality disorders. Cornelissen[29,30] found that ISTDP inpatient treatment led to positive effects on general psychopathology and general functioning measures. Solbakken and Abbass[31] found that a time-limited residential ISTDP-based treatment program for patients with treatment resistant mental disorders and comorbid personality disorders yielded large and sustained effects, including significant post-treatment improvements in relational functioning.

Based on its effects on improving anxiety intolerance and treating personality dysfunction, we hypothesized that ISTDP provided on an inpatient addictions setting would increase treatment retention and decrease relapse rates in treated clients.

Methods

Overview and design

In this pilot project, we created an inpatient drug treatment model designed for drug clients with drug addiction suffering from severe personality disorders. A drug rehabilitation facility agreed to set up a pilot study with separate treatment units for a control group (treatment as usual) and an experimental group (treatment with intensive short-term dynamic psychotherapy). The treatment was designed to help patients achieve three goals: (1) identify and regulate their anxiety; (2) see and let go of projections so that they could have a realistic relationship with other patients and staff; and (3) declare an emotional problem they wanted to work on. We hypothesized that regulating anxiety and deactivating projections would increase alliance and decrease drop out and relapse rates.

Treatment structure

Treatment began with a structured intake and assessment followed by admission to the unit where patients were in ISTDP structured groups four hours a day: (1) a psychoeducation group for two hours; (2) a therapy group for two hours; and (3) individual therapy twice a week the first two weeks and once a week during the next two weeks. Other psychoeducation meetings occurred on both the control group and the experimental group units.

During the phone intake, staff assessed whether the patient was suitable for the unit. Active suicidality, psychosis or mania requiring immediate psychiatric hospitalization and stabilization were exclusion criteria. The patient was asked four questions to detect psychotic symptoms and then invited to the clinic for

intake, assessment, and admission. If the patient revealed psychotic symptoms during the phone intake, s/he would be medicated by the psychiatrist upon arrival.

During the assessment process, the patient filled out forms and psychological measures for research and a confidentiality form giving permission to videotape psychotherapy for the purposes of supervision.

Then the patient had a structured motivational interview designed to: (1) help the patient see that what he had done before in rehabilitation didn't work; (2) ask him what he needed to do differently this time to have a different result; and (3) ask him what he needed us to do when he didn't do something differently this time. The summary of this interview, signed by the patient and the interviewer, was given to the patient's therapist.

Psychological goals of treatment

All treatment groups on the unit were designed to: (1) regulate anxiety; (2) deactivate all projections onto the staff and other group members; and (3) help the patient declare an internal problem to work on.

Anxiety regulation

Since almost all clients with drug addiction suffer from excessive anxiety, anxiety regulation was the first goal in therapy, psychoeducation groups, and the structured therapy groups. Many patients were still suffering from psychotic symptoms, detoxing, or cognitively impaired. As a result, they could not sit still and pay attention to bodily signs of anxiety. To help them, we used a biofeedback device that attaches to the earlobe and plugs into the computer (relaxing rhythms from Unyte.com).

Blocking relapse causing behavior by therapists

Therapist behaviors can cause increased dropout. Therefore, no drug counselors confronted patients until the case had been reviewed on videotape in supervision. To reduce the intensity of feelings and anxiety patients would handle, we did not ask patients to go through step four during the thirty-day inpatient treatment. To help patients with anxiety, all groups on the ISTDP unit were structured with clearly defined roles and tasks.

Psychoeducation group

During the thirty-day treatment, patients met twenty days in the psychoeducation group to learn twenty anxiety regulation, relapse behavior identification, and affect tolerance skills. The structured, manualized groups were organized around specific experiential skill building exercises to build emotional capacities that would reduce relapse. The skills were taught in a specific order to gradually build capacity for anxiety tolerance in patients.

Each meeting had a structure: (1) a period of anxiety regulation; (2) skill building which would cause a rise of anxiety; (3) anxiety regulation; (4) skill building which would cause a rise of anxiety; and (5) a final period of anxiety regulation. All patients were regulated before they returned to the unit.

Structured therapy group

We developed a structured, manualized group therapy format. Stage one: during the first week, each patient takes a turn sitting in the patient seat, named the Bold Seat. The patient's only task is to describe anxiety symptoms in the body, while s/he sits in the chair. Each patient learns to identify and regulate anxiety symptoms while sitting in the patient chair. The group must be able to regulate itself before stage two.

During stage two, structured exploration begins. Each day a different person in the group sits in the patient chair. The therapist asks the patient, "What is the problem you would like me to help you with?" Once the patient answers, the therapist turns to the group and asks them, "Was this an internal problem, anxiety, or a way to avoid declaring a problem?" Now, the entire group must think about, reflect on, and analyze the patient's response. Once the group figures out the answer, the therapist makes the next intervention. After the patient responds, again

the therapist turns to the group and asks, "Did X offer an internal problem, become too anxious, or avoid declaring a problem." Once the group responds, the therapist intervenes.

The roles and task are very clear: the patient responds to the therapist's interventions; the group analyzes the patient's responses. The structure and pace of the work keeps the rise of feelings and anxiety slow, preventing regressions in group functioning. If any patient becomes too anxious, the therapist helps the group regulate their anxiety. Exploration of feelings resumes only when the entire group is regulated.

Individual therapy

Each patient receives two hours of intensive short-term dynamic psychotherapy during the first week of inpatient treatment and one hour of therapy during the following three weeks. The first two weeks, the therapist helps the patient identify and regulate anxiety in his body. Once anxiety drops, therapists help patients see projections they place on staff and the therapist.

Helping patients tolerate feelings internally reduces the amount to which they project externally. As a result, their alliance with the therapist and staff improves. Then the therapist finds out what internal problem the patient wants to work on.

In contrast to standard ISTDP for highly functional patients, we used a modified form of ISTDP designed for low functioning patients. Our work focused on regulating anxiety, deactivating projections in order to create an alliance, and building a capacity to bear feelings inside without projecting them outside onto others.

Adherence and manuals

The drug counselors received a three-day training in ISTDP in which they learned the fundamentals of ISTDP theory and the eighteen most basic skills we believed were necessary to establish a therapeutic alliance with personality disordered clients suffering from drug addiction. Then they had a two-day training to learn how to regulate anxiety and address defenses in psychoeducation and structured therapy groups. Two of the authors (JF and TR) supervised the therapists weekly on videotapes of their therapy sessions.

In addition, the drug counselors met an hour each week to do a scripted skill building exercise focused on a specific skill. Due to the limitations of time, we were able to teach only 28 skills.

To ensure adherence, the psychoeducation group manual includes the complete script, timings, tasks, and schedule for each of the twenty meetings. The manual includes instructions for how to address anxiety in the group and the defenses that come up to keep the group on the task. The structured group therapy manual focuses on how to regulate anxiety and address defenses to help keep the group on task.

Through this structured model of intake, treatment, psychoeducation, and group therapy, we hoped to address the personality factors that might contribute to relapse and, thereby, improve outcome in severely personality disordered clients with drug addiction.

Results

Sample

Over ten weeks 20 patients were assigned to the control group and 42 to the ISTDP group. The patients were assigned randomly in that every third patient in sequence was assigned to the control group. And the patients in the control group and the experimental group were treated in separate buildings by separate staffs. The control group averaged 2.65 previous rehabilitations, the ISTDP group averaged 2.3. 10% of the control group had psychotic symptoms while 21.4% of the ISTDP group did. 5% of the control group had antisocial personality disorder, while 26% of the ISTDP group did. 15% of the control group had generalized anxiety disorder, and 33% of the ISTDP group did. 5% of the control group had panic disorder, while 33% of the ISTDP group did. The only statistically significant difference between the groups was the rate of panic disorder ($\chi^2 = 5.03$, $p < .03$).

Training

The first training took five days, followed by weekly supervision of videotaped sessions. The

project, although intended to be a long-term study, terminated after ten weeks due to funding problems at the organizational level. The supervisors kept offering weekly supervision to the drug counselors until the patients who had entered the inpatient unit had completed their treatment. Unfortunately, due to the funding limitations, only the six-month follow-up on patients is available.

Sobriety rates

Sobriety was defined as anyone remaining sober (no substance/alcohol use) since termination of treatment as assessed by phone interview. At six-month follow-up, controls had a sobriety rate of 17.6%, while the ISTDP group had a sobriety rate of 48.8%. Anyone who was sober at follow up and had maintained sobriety since leaving the unit was considered sober. Anyone we could not find we assumed had relapsed. Comparing the two groups, there was a substantial and statistically significant difference in the proportion of patients remaining sober, with the ISTDP-format outperforming treatment as usual ($\chi^2 = 4.91$, $p = .03$).

Dropout rates

Anyone who left the inpatient unit before completing the thirty-day treatment was considered a dropout. The control group had a 40% dropout rate compared to 23.8% in the ISTDP group. The dropout rate for the control group was consistent with historical averages at this setting. Dropout rate for patients in the ISTDP unit was 33% during weeks 1–5 and was 6% during weeks 6–10. By contrast, dropout rates in the control group were 30% for weeks 1–5 and 50% for weeks 6–10. The difference in dropout rate while being nearly half as much in the ISTDP group did not reach statistical significance.

Discussion

Within the methodological limitations we will describe below, this preliminary data from this pilot study suggests that an ISTDP-based 30-day inpatient drug rehabilitation program focusing on psychological problems that increase relapse can decrease dropout and increase sobriety. The outcomes also suggest that structured training for drug counselors focusing on the deliberate practice of specific skills may increase their effectiveness and, thus, the sobriety outcome for their patients.

We saw improved retention rates in the second half versus the first half of the study, suggesting that training effects may have added benefits in ISTDP versus control groups. These findings align with research that therapist conduct is a greater determinant of outcome than patient characteristics.[12] Further, the results are also consistent with McKellar et al's[13] finding that high risk addicted patients do best in a treatment structure that is high in support and low in control. And, finally, the results support previous research indicating that short-term dynamic psychotherapy[14] plus medication[15] can lead to improved outcome and enduring change in this population.

While the results are promising and suggest that ISTDP may carry benefits over treatment as usual, other factors could have influenced the outcome. First, therapist enthusiasm for a new approach may have impacted outcomes. Second, therapists selecting themselves for an innovative emotionally focused program may have biased the treatment received. Third, these two factors may have resulted in higher expectations of gains in patients. Fourth, follow-up was limited to six months. The use of a control group helps validate the findings and offset some of these factors but staff were not randomly assigned to groups. The study could not collect outcome measures to evaluate whether anxiety reduction or other factors related to outcomes due to funding limitations and closure of the facility.

Future research should explore the effects of this approach in other inpatient and outpatient facilities to test its generalizability. Such studies should examine the degree to which anxiety regulation and therapist skill-building correlates with patient outcome. Videotape analysis of therapists with better outcomes might allow us to identify behaviors that improve outcome.

Conclusion

A 30-day inpatient program based on ISTDP treatment emphasizing anxiety regulation, handling of projection and regulating therapist

interventions appears to be beneficial in treating complex clients with drug addiction. Future study is warranted to examine ISTDP's long-term effects, study moderators of effects and study its efficacy using a randomized controlled design.

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