Ulm Conference: Non-Responders: Can we identify what keeps a substantial portion of patients from responding in psychological therapies?

Organized by Erhard Mergenthaler (Ulm) October 2008

A Clinical Overview on Non-Responders

Horst Kächele

It is a pleasure and an honour to open this conference with some clinical remarks on a topic that has accompanied the development of the field although camouflaged in many ways. Freuds case reports provide illustrations of patients not responding to his efforts as the case of the Wolfsman (Freud 1918b) clearly illustrates. After four years of the patient non-responding to Freud´s efforts, Freud set a date for termination which finally brought for what Freud was looking for. As the subsequent fate of the patient illustrates, he remained a kind of chronic non-responder as has been summarized by Muriel Gardiner (1971).

Later psychoanalysis having been institutionalized at the Berlin Institute Fenichel published a review (Fenichel 1930). It allows the conclusion that by using the concept of ‚trial analysis' this group of early outcome specialiss was aware that not everybody could make use of the specifics of psychoanalytic therapy. Would the concept of non-responders cover these therapist initiated trial phases?

	trial analysis	early inter-ruption	uncured	improved	much im-proved	cured
Hysteria	105	31	6	22	21	25
Schizoid	45	26	8	8	2	1
Ob-session	106	35	6	18	26	21

Or is it only the group of the uncured? So what is the difference between failure and non-responding to treatment?

Anyhow this issue is a wonderful topic directed to the very heart of the clinical enterprise. Imagine a surgeon who after many hours at the operation table draws the conclusion: I am afraid this man is a non-responder; at least we have tried to do our best.

Are there indeed cases where even the best psychotherapist has to admit: I am afraid this man is a non-responder; at least I have tried to do my best.

It is a good custom to first consult an etymological dictionary before plunging into unknown water:

> ORIGIN late Middle English (in the noun senses): from Old French, from ***respondre 'to answer,'*** from Latin ***respondere***, from ***re- 'again'*** + ***spondere 'to pledge.'*** The verb dates from the mid 16th century.
>
> ay something in reply : [intrans.] *she could not get Robert to* ***respond to*** *her words* | [with clause] *he responded that it would not be feasible* | [with direct speech] *"It's not part of my job," Belinda responded.*
>
> • (of a congregation) say or sing the response in reply to a priest.
>
> • [intrans.] (of a person) act or behave in reaction to someone or something : *she turned her head,* ***responding to*** *his grin with a smile.*
>
> • react quickly or positively to a stimulus or treatment : *his back injury has failed to respond to treatment.*

From this definition from the Oxford American Dictionary we may learn that to respond means to react quickly or positively to a stimulus or a treatment. However I shall open my discussion with an unusual bird´s eye view:

A research team from the Central Institute of Psychic Disordes Mannheim for more than fifteen years studied a large random sample of the population (N= 600) from a German city (Schepank 1987). Trained interviewers identified 25% that received a diagnosis of a psychological disorder. About fifty percent of these potential candidates for psychotherapy declared to have a motivation for treatmet if provided with an option for it. Alas, only one fifth of these motivated people found the way into a psychotherapeutic treatment. Are all the others non-responders? Obviously prevalence of psychic disorder and motivation for treatment and readiness to start a treatment – even if funding is provided by insurance - are only loosely interconnected. The same phenomenon has been studied for many somatic disorders like hypertension. Lack of compliance with treatment recommendations tends to be a common issue.
So we may identify a first group of non-responders as those who do not test out treatment at all.

What about those patients that have engaged in the experiment of a treatment? The issue who responds to psychotherapy and who does not has remained in the shadow of the overwhelmingly positive answers the field, write Lambert & Ogles (2004) in their recent review. But evaluation of treatment outcome usually connected to the date of termination, much less so to a later date. There are even no agreed upon time periods at which follow-up should take place. The range of follow-up time spans is huge varying between a few months and more than ten years (Meyer et al. 1989).
Let me remind you of a noteworthy study, the Treatment of Depression Collaborative Research Program (TDCRP), which often proudly is cited for its performance; however the follow-up perspective reads quite sobering:
Only approximately 20% of the patients of this landmark investigation, for example, were rated as fully recovered—as having a reduction in symptoms at termination without substantial relapse in the 18 months following the termination of treatment (Shea et al., 1992).

We may learn from that landmark study that the notion of response is tightly connected to the time of evaluation; early response is not conclusive for long time response. In this vein a recent editorial in the American Journal of Psychiatry by Levy points out that

„following the seminal study by Linehan et al. comparing dialectical behavior therapy with treatment as usual, there have been a number of randomized, controlled trials establishing the efficacy of various cognitive and psychodynamic treatments for borderline personality disorder. Most, but not all, of these studies have included some short-term follow-up assessment. Given the entrenched and chronic nature of borderline personality disorder, long-term follow-up is central for establishing the significance of these treatments. However, the time frames in these follow-ups have been relatively short, between 6 and 18 months, leaving the long-term efficacy of these treatments unclear".

Levy further details

"given that even the most potent of the available treatments are limited in their effects, helping many but not all patients and resulting in only partial and/or temporary recovery, research needs to focus on understanding the therapeutic mechanisms that lead to change in these patients" (Levy 2008).

I tend to think we have to add the issue what kind of therapeutic effort on the part of the therapist is conducive to implement these mechanisms. These efforts are especially required in the handling of ruptures and their resolutions a topic that rightly has been covered at the recent SPR meeting in Barcelona (Coutinho 2008; Horvath 2008); it has a lot to do with therapist´s countertransference to these events (Linguiardi & Colli 2008)[1].

Since long the problem has been recognized as being crucial for the treatment of borderline patients undermining many efforts:

<u>Clinical example 1</u>

A patient of mine suffering from ten year long state of chronic suizidal ideation being in a once a week supportive regimen that kept her alive but not well approached me as „famous author" of a textbook willing to make a last effort or else she would kill herself. During the first year she terminated the treatment ten times by sending a fax after a session. My way of calling her via telephon on the nex day and asking her

[1] The topic of rupture and repair of cooperation in Borderline Personality Disorder recently has been studied in an experimental setting (King-Casas et al 2008).

what I had missed in the session, where I had failed her, helped to undo the ruptures of the alliance.

The recent presidential address of Jacque Barber at the SPR meeting in Barcelona takes up this line of critical though on which patient with whom will make it:
„No single therapy is likely to be most efficacious in all cases, and a therapy with a high success rate among certain subtypes of patients and in certain situations may not be as effective in another context".
The question of which therapy is best has to be supplemented by the question, ''Which factors contribute to positive outcomes in each type of therapy, in different therapies, and across therapies?'' (Barber 2008, S. 131).
Understanding the factors that are responsible for the range of patient outcome in specific treatments may enable us to recognize the most suitable treatment for each patient. More work is needed in refining what makes some patients unlikely to have good outcome (e.g.,''patient difficulty'') or to be attentive to factors in the therapist that may contribute to the patient´s fate.
These a wise statements from an enthusiastic treatment researcher.
For an enthusiastic clinician, however, the whole concept of non-responders is bestowed with a serious problem. Who decides when a treatment shoud be declared as a failure, who is courageous enough like a surgeon saying: sorry we have failed.

Clinical example 2. Treatment resistent anorexia nervosa patient

A seventeen year old adolescent is brought to our psychosomatic unit in the Medical Hospital. Her BMI is 11; the status of her bone mineralization is deplorable similar to that of an old lady. For weeks and weeks the staff does not see any improvement on her somatic parameters. It is only due to the tenacious plea of her individual therapist, Dr. Rose, that the team consents to go on with treatment with an open time perspective. The colleague – truely involved as she is treating one of her first patients in individual therapy - tells us that the patient is growing psychically – whatever that means. She observes that the phantasy life of the young emaciated[2] patient develops, becomes more differentiated which she supports by showing us the

[2] *emaciated bodies* thin, skeletal, bony, gaunt, wasted; scrawny, skinny, scraggy, skin and bones, rawboned, sticklike, waiflike; starved, underfed, undernourished, underweight, half-starved; cadaverous, shriveled, shrunken, withered; informal anorexic, like a bag of bones. antonym fat.

painting of the girl and that her personal contact to the girl becomes more personalized.
After four months of inpatient treatment – with some modest improvement in weight - the patient is transferred to our day clinic where she still does not alter much her weight parameters, but continues to absorb the multi-modal incentives of the treatment program. A major step in the treatment regimen was the placement of the patient in a local forster family to help the patient to decrease her enmeshment with her mother[3].
On top she continued to stay in e-mail contact and weekly sessions with her therapist. Obviously both had developed a strong mutual affective bond - to put it mildly. To make a long story short, after quite some relapses necessitating re-hospitalization, two years later Dr. Rose proudly reports to the team that her patient has passed the Abitur and is about to enroll as a student.
This case ilustrates that there are always various options for a therapist among which to choose given the availability of a suitable environment. To follow guidelines is one, to insist on one´s own strong inclination – you may call it countertransference – is another that in psychotherapy most likely may play a decisive role. Wallerstein (1986) spoke of heroic indications when a therapist decides to work with a patient against all handed down wisdom.

Clearly from the usual criteria in eating disorder research this patient was a non-responder. If she would not have shown a distinct weight gain after four weeks, we could predict that at the time of the 2.5 follow-up she would turn out as a treatment failure in the large scale, nationwide study of psychodynamic inpatient treatment (Kächele et al. 2001; Hartmann et al. (2007).
However looked from a larger time perspective the concept of non-responders to the index treatment has to be supplemented by a concept that sees remissions and relapses as part of the natural history of disorders (Richard et al. 2005).
A careful tabulation of succeeding treatments following the index treatment in our study demonstrates most of the patients use further outpatient (62%) or inpatient treatments (10%). In a second step from the 62% outpatient patients one fifths returns to another outpatient treatment, one tenth to another inpatient treatment.

[3] Engel et al (1989) showed that leaving the primary family net was connected to positive long term outcome

There is even a third wave of treatments needed by 7% of the original patient population.

One can argue that given a specific intervention there are some patients that can be characterized as not responding to this single intervention. As long as we discuss the phenomenon of non-responding in the common frame of short-term interventions, it may make sense to study this issue.
However the reasons for initial failure of a treatment may reside not only in a patient´s failing capacity to absorb a treatment, but also in a therapist´s capacity not to provide the adaequate intervention. So the issue may be: who cares for whom in what way.

Clinical example 3 Recurrent depression in a narcisistic personality disorder
A forty-five year old male patient comes to our clinic in a state of open suicidal ideation. He reports to have been a number of times being admitted to the psychiatric hospital for recurrent depressions over the last ten years. Drug treatment only alleviated his repated states of despair, but did not alter the basic issues which rendered him vulnerable time and again. Given the diagnosis of a narcisstic personality disorder any of the available short term interventions be it CBT, IPT or psychodynamic short term therapy would have been a pure waste of time and effort. In this vein Westen & Morrison (2001) conclude: „Meta-analyses have shown that only about 50% of depressed patients respond (defined as a 50% reduction in symptoms) to pharmacological or psychotherapeutic treatments“. Furthermore, many patients who respond to brief treatments continue to show subclinical symptomatology, with an average post-treatment BDI score of 10.98 as has been pointed out by Luyten et al. (2006).

Even without the metaanalytic knowledge available it was clear to me that for this patient the indication of a long term psychoanalytic therapy was given. Deeply ingrained features of personality hardly are impressed by the weak efforts of a once a week encounter (Perry et al. 1999).
Four years later the patient left treatment to return ten years later for another dose of low frequent therapy for about one year.

Our present study on chronically depressed patients treated by psychoanalytic therapists studied by fMRT and EEG represents a typical sample of these clientel (Buchheim et al. 2008). They all have been non-responders, or short term responders of other shorter psychotherapies or drug treatments. It is a fortuitous fact that our colleagues Leichsenring and Rabung (2008) have just achieved to get a meta-analysis on the „Effectiveness of Long-term Psychodynamic Psychotherapy“ published in JAMA.
How large ist the therapist´s influence on patients not being able to improve. Ever since Luborsky et al. (1985) documented the phenomenon of differential impact of therapists´we should be more attentive this factor.
The Stockholm group of Rolf Sandell has studied the „Therapists' attitudes and patient outcomes“ (2006) in extended psychoanalytic therapies. A sample of 160 therapists were clustered in a nonparametric LC regression modelling of their patients' repeated self-ratings on the SCL-90 across stages in psychotherapeutic treatment. This classification was then explored in relation with the therapists' TASC-2 scores.

Five classes were identified differing widely in terms of the patients' outcome trajectories. Membership in these classes was significantly influenced by the therapists' scores on the TASC 2 scales. The adjustment, neutrality, and artistry scales of the TASC 2 were found specifically discriminative. A discriminant analysis confirmed the findings in general. Collectively, the TASC 2 scales were able to assign 59% of the therapists to their correct latent class, a reduction from chance by 39%.

The following conclusion makes a specific point: Therapists with a psychoanalytic or eclectic orientation are systematically different in terms of the outcomes they tend to contribute to with their patients. This variation is partly accounted for by differences in their therapeutic attitudes.

So for our discussion on non-responders do we have to pay more attention to a therapists´ group of non-providers?

Clinical example 4 Stagnation and the decision to change therapist

If stagnation or an impasse happens to occur in a treatment, analysts can usually find very plausible reasons for it in the patient's psychodynamics. It is logical for them to think of a negative therapeutic reaction (Freud 1923b).

This attitude disregards, however, the therapist's contribution to the stagnation. If therapeutic change is missing, part of the responsibility probably lies in the therapist's personal equation and technique (Thomä & Kächele 1992).

Because of a protracted standstill in her therapy, Maria X consulted, by mutual agreement with her (female) therapist, another analyst, this one a man. Each side experienced the futility of the therapeutic work, yet drew different conclusions from it. The patient was absolutely against terminating, while the therapist recommended a break and left it to her discretion to later switch to a male analyst. This pessimistic point of view was the result of the fact that all of the female analyst's efforts to communicate something good to the patient, who had diffuse anxieties and whose general mood was depressive, had apparently failed. The patient's chronic dissatisfaction with herself and the circumstances of her life, which was caused by a fundamental feeling that she was deficient, had remained inaccessible for a period of almost two years. Since the patient's response to each insight into unconscious conflicts led to a deterioration in her condition, the analyst diagnosed a negative therapeutic reaction.

Switching the therapist made a change especially because the male therapist focused relentlessly on her negative cognitions, on her negative expectations that nothing good could come out of the joint work. One year later Maria left treatment with distinctly more positive views on her life. The cognitive approach had helped her definitely more than the effort to identify unconscious conflicts.

Conclusion: Patients´ non-responding to psychotherapy has many good and bad reasons. Patients´ needs to defend their protective shield as developmental accomplishment may be one; others may reside in the unability of their therapists of giving them what they need. But we should also not forget that there a times for change in a life, and not always therapy is offered at the wrong moment. Luckily patients can returned for another try. Recently an American analyst has proudly reported on a patient that has survived twenty years of classical analysis without any change. He now with in more relational technique based on good measures reports about substantial progress in the next six years (Josephs et al. 2006).

Obviously never give up sometimes is a good motto. The most non-responding patient of the Ulm data bank, Christian Y, maintained his status as a chronic anxiety patient based on his narcissic personality makeup for about 500 sessions; finally he

was able to get back to live, resume his studies. The analyst, Dr. Thomä never gave up and worked for a total of 1300 sessions across twenty years; however the patient now lives a happy creative live. Too often non responders just fall short of the available therapist that struggles with her or him.

Bateman AW, Fonagy P (2008) 8-year follow-up of patients treated for borderline personality disorder: Mentalization-based treatment versus treatment as usual. Am J Psychiat doi: 10.1176/appi.ajp.2007.07040636

Buchheim A, Kächele H, Cierpka M, Münte T, Kessler H, Wiswede D, Taubner S, Bruns G, Roth G (2008) Psychoanalyse und Neurowissenschaften: Neurobiologische Veränderungsprozesse bei psychoanalytischen Behandlungen von depressiven Patienten - Entwicklung eines Paradigmas. Nervenheilkunde 5: 441-445

Coutinho J (2008) The role of rupture resolution processes in therapeutic alliance. 39th SPR, Barcelona 2008

Dammann G, Clarkin J, Kächele H (2000) Psychotherapieforschung und Borderline-Störung: Resultate und Probleme. In: Kernberg OF, Dulz B, Sachsse U (Hrsg) Handbuch der Borderline-Störungen. Schattauer,, Stuttgart New York, S 701-730

Engel K, Wittern M, Hentze M, Meyer AE (1989) Long-Term Stability of Anorexia Nervosa Treatment: Follow-Up Study of 218 Patients. Psychiatric Developments 4: 395-407

Fenichel O (1930) Statistischer Bericht über die therapeutische Tätigkeit 1920-1930. In: Radó S, Fenichel O, Müller-Braunschweig C (Hrsg) Zehn Jahre Berliner Psychoanalytisches Institut. Poliklinik und Lehranstalt. Int Psychoanal Verlag, Wien, S 13-19

Freud S (1918b) From the history on an infantile neurosis. SE vol XVII: 1-122

Freud S (1923a) "Psychoanalyse" und "Libidotheorie". S 209-233, GW Bd 13

Gardiner M (1971) The wolf-man by the wolf-man. Basic Books, New York

Hartmann A, Wirth C, Zeeck A (2007) Prediction of failure of inpatient treatment of anorexia nervosa from early weight gain. Psychotherapy Research 17: 218-229.

Horvath AO, Bedi RP (2002) The alliance. In: Norcross JC (Hrsg) Psychotherapy relationships that work: Therapist contributions and responsiveness to patient needs. Oxford University Press, New York, S @@

Harmon C, Hawkins EJ, Lambert MJ, Slade K, Whipple JS (2005) Improving outcomes for poorly responding clients: The use of Clinical Support Tools and feedback to clients. Journal of Clinical Psychology: In Session, 61: 175–185.

Horvath AO (2008) A conceptual analysis of the literature on the rupture-repair cycle. 30 SPR, Barvelona 2008

Josephs L, Anderson E, Bernard A, Fatzer K, Streich J (2006) Assessing progress in analysis interminable. J Am Psychoanal Assoc 52: 1185-1214

King-Casas B, Sharp C, Lomax-Bream L, Lohrenz T, Fonagy P, Montague PR (2008) The Rupture and Repair of Cooperation in Borderline Personality Disorder.

Science 321: 806

Leichsenring F, Rabung S (2008) Effectiveness of Long-term Psychodynamic Psychotherapy. A Meta-analysis. JAMA, October 1, 2008—Vol 300, No 13

Linguiardi V, Colli A (2008) Therapist´s countertransference and alliance rupture and resolution processes: an empirical investiagtion through the lens of Countertransference Assessment Q-Sort CTA-Q(and Collaborative Interaction Scale (CIS). 39 SPR, Barcelona 2008

Luborsky L, McLellan AT, Woody GB, O'Brien CP, Auerbach AH (1985) Therapists' success and its determinants. Arch Gen Psychiat 42: 602-611

Luyten P, Blatt SJ, Houdenhove Bv, Corveleyn J (2006) Depression research and treatment: Are we going skating where the puck is going to be. Clinical Psychology Review 26: 985-999

Meyer AE, Stuhr U, Wirth U, Rüster P (1989) 12 year follow-up studies of the Hamburg short psychotherapy experiment. Psychother Psychosom

Perry JC (1999) Effectiveness of psychotherapy for personality disorders. Am J Psychiat 156: 1312-1321

Richard M, Bauer S, Kordy H (2005) Relapse in anorexia and bulimia nervosa. A 2.5-year follow-up study. European Eating Disorders Review 13: 180-190

Sandell R, Lazar A, Grant J, Carlson J, Schubert J, Broberg J (2006) Therapists' attitudes and patient outcomes: III A latent class (LC) analysis of therapies. Psychol Psychother 79: 629-647

Schepank H (1987) Epidemiology of Psychogenic Disorders. The Mannheim Study - Results of a Field Survey in the Federal Republic of Germany. Springer, Berlin -. Heidelberg - New York

Thomä H, Kächele H (1991) Psychoanalytic Practice, vol. 2: Clinical Studies. Springer, Berlin, Heidelberg, New York, Tokyo

Wallerstein RS (1986) Forty-two lifes in treatment. A study of psychoanalysis and psychotherapy. Guilford, New York

Westen D, Morrison K (2001) A multidimensional meta-analysis of treatments for depression, panic, and generalized anxiety disorder: An empirical examination of the status of empirically supported therapies. J Consult Clin Psychol 69: 875-899.