CHAPTER 21

RESIDENTIAL PSYCHOTHERAPEUTIC TREATMENT

An Intensive Psychodynamic Approach for Patients With Treatment-Resistant Disorders

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Changes in Health Care and the Problem of Treatment Resistance

The transformation of both the delivery and funding of health care in the last part of the twentieth and early twenty-first centuries had a dramatic impact on the nature of hospital psychiatry. Increasing recognition of escalating health care costs led to the emergence of managed care, with a concomitant decrease in length of inpatient psychiatric stays, a shift in inpatient focus from definitive treatment to crisis intervention, more attention to biological treatments, and early discharge planning aimed at moving patients quickly to less restrictive and usually outpatient settings. In response to these changes, a number of high-quality, long-term treatment centers closed their doors, patient readmissions to inpatient hospitals increased, and the doctor-patient relationship continued its transformation from an intimate encounter to a bureaucratically structured negotiation of the need and terms of treatment with third-party payers (Geller 2006; Plakun 1999; E.R. Shapiro 2001b).

Although many patients struggling with mental illness have benefited substantially from advances in biological treatments and short-term cognitive-behav-
ioral interventions, available data indicate the limitations of these approaches. For example, perhaps one-third of patients with schizophrenia fail to respond or respond inadequately to antipsychotic medications [American Psychiatric Association 2004], whereas nearly 75% of patients in the Clinical Antipsychotic Trials in Intervention Effectiveness study discontinued the study medication regimen before 18 months of treatment [Lieberman et al. 2005]. Between 15% and 50% of patients with mood disorders are treatment resistant [Foa and Davidson 1997; Thase et al. 2001], and only a minority of these fully recover on medications alone [Rush and Trivedi 1995]. Results from the STAR*D trial of treatment for patients with major depressive disorder demonstrate that substantial numbers of patients fail to respond adequately either to initial treatment or various switch or augmentation strategies, including short-term cognitive-behavioral therapy [Thase et al. 2007]. In adolescents with depression there are also significant rates of treatment resistance [Apter et al. 2005; Treatment for Adolescents With Depression Study Team 2003], and, for the subset of patients with chronic major depressive disorders and histories of serious childhood trauma or abuse, there is evidence that psychotherapy may be more effective than medication [Nemeroff et al. 2003].

For patients with bipolar disorder, the Systematic Treatment Enhancement Program for Bipolar Disorder study reports that only slightly more than half achieved recovery, and half of these had recurrences within 2 years [Perlis et al. 2006]. Miklowitz et al. [2007] demonstrated that intensive longer-term psychosocial treatment as an adjunct to pharmacotherapy is more beneficial than brief treatment in enhancing stabilization from bipolar illness.

The presence of personality disorder—particularly borderline personality disorder—makes a significant contribution to treatment resistance in mood disorders. Data from the Collaborative Longitudinal Personality Disorder Study suggest that personality disorders adversely affect the prognosis of major depressive disorder and are in themselves significantly associated with persistent functional impairment, extensive treatment utilization, and significant risk of suicide [Bender et al. 2006; Skodol et al. 2005]. It is not surprising, then, that treatment-resistant illnesses are expensive. The cost of treating patients with treatment-refractory mood disorders, for example, is 19 times higher than the cost associated with treating more responsive patients [Crown et al. 2002].

Patients with these treatment-resistant illnesses are often caught up in repeated and ongoing crises in their outpatient treatments with efforts to ward off the next suicide attempt or the need for another hospital stay. For some the risk of suicide has been the central issue keeping them in a state of crisis; for others it has been chronic inability to manage the transition from the role of child in the family to that of functioning and autonomous adult in the world.

In our own focus group discussions with graduating psychiatric residents and practitioners in New York City, Chicago, and Los Angeles, we heard the repeated view that patients with treatment-resistant illnesses were inevitably doomed to chronic crisis management. Many of these clinicians believed that there were no specialized resources for these patients beyond what they could find in their own urban setting or region.

**Intensive Residential Treatment: The Austen Riggs Center**

Longer-term treatment is generally utilized for those patients with disorders that fail to respond or respond inadequately to outpatient treatment and short-term inpatient settings or who have difficulty sustaining independent functioning. Several specialized inpatient settings offer longer-term treatment ranging from 1 to a few months [Menninger, Sheppard Pratt, McLean, and others], but for patients whose treatment-refractory disorders require a more extended period of treatment, residential programs with a continuum of care that allows progressive step-down in staffing intensity and cost, such as that provided at the Austen Riggs Center, are often required.

The range of available residential settings is fairly wide, including some programs offering primarily custodial care for patients whose illnesses fail to respond to usual treatment and have become chronic (often patients with psychotic spectrum or pervasive developmental disorders). Many of these programs are behaviorally focused, and some use token economies. Some longer-term residential programs offer a work environment with psychiatric support within a home, farm, or guesthouse milieu.

There is evidence, however, that for patients with severe personality disorders an extended residential treatment program with a psychodynamic focus and a continuum of care promotes social adaptation, reduces symptoms [including the frequency of self-harm and suicide attempts], and decreases the length and frequency of readmission [Chiesa et al. 2004]. In addition, data from Austen Riggs [Fowler et al. 2004;
Plakun 2003; Perry et al., in press) suggest that longer-term psychodynamic residential treatment with step-down programs can be useful for that subset of patients with treatment-refractory Axis I disorders who have comorbid Axis II disorders—especially when there is a history of prominent early trauma, abuse, loss, deprivation, or neglect.

For this last group, treatment resistance is often a phenomenon related to personality pathology, ordinarily manifest in disturbances in interpersonal relatedness. Organizing treatment around these personality resistances offers a focused and precise intervention. This group of patients may be able to use a longer-term hospital or residential treatment that addresses these issues to overcome the chronic risk of suicide, achieve delayed age-appropriate role functioning, and take charge of their lives in a way that breaks the cycle of crisis and despair.

Intensive residential treatment for this population—offered at the Austen Riggs Center—adds to general psychiatric treatment a set of specialized and intensive individual, family, group, and milieu psychotherapeutic and psychosocial treatment components (Elmendorf and Parish 2007; Fromm 2006; Mintz and Belnap 2006; Muller 2007; Plakun 2006) intended to interrupt the often rageful cycles of failure these patients experience while providing an opportunity for them to take charge of their treatment and their lives in new ways.

The Patients

Who are these patients? The prospective, naturalistic, longitudinal Austen Riggs Center Follow-Along Study has been following 226 patients every 6–8 months during and after treatment at Riggs for a mean of 9 years. Our data indicate complex diagnostic comorbidity, with a mean of six Axis I and II disorders (Plakun 2003; Perry et al., in press). Fully 80% of the patients have treatment-refractory mood disorders that have failed to respond to standard interventions in inpatient and outpatient settings. More than 80% of patients also meet criteria for one or more personality disorders, most commonly borderline personality disorder. Two-thirds of patients have histories suggesting significant early adverse experiences of abuse, trauma, neglect, loss, or deprivation, and one-third meet criteria for posttraumatic stress disorder. Nearly half have substance use disorders complicating their clinical picture, and about one-quarter have symptoms of an eating disorder. About 15% present with psychotic spectrum disorders.

Beyond diagnosis, these patients typically have not been able to benefit from treatments of lesser intensity and have been unable to sustain functioning between outpatient sessions without the support of chronic crisis management. They demonstrate repeated struggles with authority deriving from early family dynamics, often presenting histories of family conflict around the management of relationships and generational role boundaries (Berkowitz et al. 1974; E.R. Shapiro 1982a; E.R. Shapiro and Freedman 1987; E.R. Shapiro et al. 1975). In response to problematic family dynamics, their struggles with authority contribute to considerable and frequently unconscious rage at clinicians who take up the authority role (Prelinger 2004; E.R. Shapiro 2004). Although this aggression can be a useful element for patients to learn about during the course of treatment, many outpatient clinicians do not have the specialized training or experience to notice, focus on, withstand, or productively engage these patients’ rage at authority (Kernberg 1984; Plakun 2006; E.R. Shapiro 1982b; Winnicott 1949).

These patients often use actions rather than words for communication of intense and unbearable affect states; many have histories of recurrent self-injury and/or suicidal behavior. They have often been unable to adhere to prescribed medication regimens, are exquisitely sensitive to side effects or induce countertransference reactions in the prescribers that confound treatment efforts (Mintz 2002). On admission to Austen Riggs, 50% of patients have made at least one potentially lethal suicide attempt, more than 40% have had six or more episodes of self-destructive behavior, and 60% have had three or more previous hospitalizations. Examination of patient histories indicates early trauma, abuse, neglect, loss, or deprivation in about 60%. A period preceding admission involving a downward spiral into chronic crisis management is typical, with repeated maladaptive patterns in relationships and behavior and multiple treatment failures involving medication trials and inpatient and outpatient treatment.

Nevertheless, these are also individuals with strengths. Many have had earlier life trajectories with academic, athletic, or artistic promise that collapsed as their symptom picture unfolded—often beginning during the period of late adolescence and early adulthood. Either the task of moving from the role of child in the family to that of adult in the world has been unmanageable during this developmental transition (Erikson 1964a, 1964b; R.L. Shapiro 1963) or later in life they fall apart when a long-standing adaptation crumbles in the face of a loss or life transition (e.g., parental death, the end of a long-term relationship, the repetition of abuse). These patients appear to have the
capacity—although usually not the experience—for learning how to use words to describe their feelings while tolerating the associated affects. They indicate a readiness to learn how to delay acting on their impulses. Often they are at a point in their lives where they are poised between increasing desperation and readiness to change.

**Basic Dilemmas in Constructing Treatment**

These patients raise three central dilemmas for treatment:

1. **Alliance:** Because of difficult past experiences with caregivers, these patients fear and resist a treatment alliance. To engage them in an atmosphere that maximizes interdependency and engagement in the task of treatment requires an unrelenting focus on their own authority and the importance of relationships.

2. **Limits:** In response to efforts by others (e.g., family, society, treaters) to set reasonable external behavioral limits and controls, these patients inevitably see the limits, because of their life experiences, as arbitrary, unempathic, and rigid. In response, they may attempt to defy limits and blame limit-setters for their own self-destructive behavior. To construct a treatment environment that puts them in charge and offers opportunities to gain perspective on their anger and the developmental context for their attack on limits—while helping them to remain safe—is a formidable task. When the patient's strengths allow it, treatment is optimally carried out in a completely open setting that requires careful negotiation and ongoing maintenance of a therapeutic alliance (Knight 1953), with differential authority for patients and staff. The staff's recognition of patient authority and the responsibility that goes with it create the basis for a therapeutic community. Interdependent and clearly defined role relationships in such a community emphasize the centrality of the commitment by both patients and staff to the treatment process (Kubie 1960).

3. **Behavior:** These patients tend to use actions to communicate rather than words. To construct a treatment in which they have the opportunity to recognize and acknowledge the meaning of their behavioral communications, translate their experience into language, bear the associated feelings, and put their feelings into historical perspective requires a therapeutic community with a focused task. Such a community can focus on "examined living," providing feedback about the meaning and impact of behavior and allowing patients to develop a language for experience to bring into their individual psychotherapy and family work (Belnap et al. 2004; Elmendorf and Parish 2007; Fonagy et al. 2002; Fromm et al. 1986).

**Determination of Suitability for Residential Care in an Open Setting**

The program at Austen Riggs is predicated on these core notions; thus, the admission consultation explores them in detail. The prospective patient's capacity to take up his or her own authority in the admission negotiation, use the relationship with the admissions officer for learning, and open the possibility of finding meaning in symptoms determines the patient's suitability for treatment. Admission requires an explicit offer from the admissions officer after a 2-hour consultation with the patient alone and with relevant family members. The patient's interest in accepting the offer—however ambivalently—with acknowledgement of the anxiety that must inevitably accompany the freedom of the setting indicates the beginning of an alliance. Similarly, any third party who may be supporting the treatment financially, such as a relative or insurance company, must also agree to the conditions of treatment.

A central aspect of the admission consultation is a negotiation with the prospective patient and family (if available) about managing the risks of the open setting. When the patient's treatment-resistant illness is organized around a rebellion against authority, it may be manifest in an abdication of responsibility, with the expectation that those in authority will take over [and fail]. This becomes apparent at admission when a patient's presentation seems to insist that it is the institution's job to keep him or her alive. Admissions officers regularly note with patients the way this implicit or explicit expectation is an impossible task.

Admission is dependent on patients beginning to recognize that it is their responsibility to manage their safety [or commit to inform staff if they become unsafe], while staff takes responsibility for overseeing the treatment process. Inevitably, engaging in and maintaining this negotiation is not possible for some—and 15%-30% of those admitted are ultimately not able to tolerate the responsibility sufficiently to sustain their treatment. Nonetheless, such an initial alliance—although often shaky and requiring ongoing vigilance—offers the best chance for a treatment process that pa-
patients can own as the first step in taking charge of their lives. This opening discussion with patients and their families also helps put family anxieties and unrealistic expectations in perspective and begins the process of defining clearer roles in treatment.

The following vignette illustrates some of these points. The case and treatment principles related to it are described in more detail elsewhere (Plakun 2003).

Ms. A was a widowed woman in her 40s with treatment-resistant depression and a borderline personality disorder who was referred to the center because of recurrent suicidal ideation and behavior that kept her outpatient treatment chronically in crisis. Her insurance company agreed to support longer-term treatment because of the high cost to them of multiple previous short-term hospitalizations and in recognition of her high suicide risk. In the admission consultation Ms. A was able to engage with the admissions officer about the rage and despair beneath her recurrent suicidal threats and their link to an early history of sexual abuse and fears of abandonment, exacerbated by her husband’s death several years earlier. She found the discussion of these issues and the tentative connections drawn between her symptoms and life history helpful and surprisingly calming, noting that she and her outpatient psychiatrist had rarely had the opportunity to explore anything but her response to medications and the level of her suicide risk. She felt able to contain her suicidal behavior if admitted, and admission was offered.

Although the patient’s insurance company was willing to support treatment 1 week at a time, it would not commit in advance to the minimum stay of 6 weeks. As a result, the patient, who had the resources, was asked to make the usual prepayment to secure the initial period of evaluation and treatment. On the day before admission the patient called to indicate her refusal to make the required prepayment, stating that if she were not offered admission anyway, she would carry out her suicide plan. The admissions officer noted her use of a suicide threat to get her way and reminded her of the work they had done to get an initial perspective on her struggles. He reminded her of her competence and determination in negotiating coverage with her insurance carrier and said it would be too bad if she threw away the chance for a treatment that might work. He then told her that he would not allow her to come in any way other than the one they had negotiated, which was the same for all patients admitted. Although initially enraged, Ms. A was also reassured by the holding of limits, made the prepayment, and was admitted.

**Treatments**

Many of these patients come from multiple short-term inpatient hospitalizations in locked settings in major cities. The Austen Riggs Center presents a striking contrast. A completely open residential treatment center in stately white buildings on the main street of the small New England village of Stockbridge, Massachusetts, the center offers a semirural setting for voluntary treatment. There are no privilege systems, no locked doors, and no explicit requirements to attend any treatments, although a lack of attendance inevitably leads to review of the patient’s interest in treatment.

Patients are admitted for an initial 6-week period of intensive evaluation and treatment, although most stay longer. The median length of treatment in the continuum of care (from hospital level through step-down programs to outpatient care) is 6 months, with a range from 6 weeks to several years. In general, the effort is to interrupt the cycle of thwarted treatments by helping patients develop the capacity to express experience in language. This capacity increases the likelihood that after discharge patients will be able to manage outpatient psychotherapy without self-destructive behavior or other recurring crises interrupting the work and with new abilities to engage in adaptive social role functioning.

Although a brief-stay inpatient level of care is available for patients whose treatment alliance becomes uncertain during the course of treatment, the vast majority of patients enter a therapeutic community at one of two residential levels of care organized around the maximal exercise of patient authority and the possibility of turning to others for support. The more intensive residential program focuses on individual nursing care (often used with patients struggling to contain impulses to harm themselves or to use substances), whereas the other has less intensive nursing and relies more on peer groups. Having been screened at admission for their capacity to engage in a verbal psychotherapy, all patients begin and throughout their stay continue in four-times-weekly psychodynamic psychotherapy with a doctoral-level therapist. In addition, skill-based and symptom-focused groups are available in the community program. All patients have a psychopharmacologist who prescribes medication for sufficient symptom relief to allow the patient to participate fully in the range of treatments. Social workers—often with the individual therapist as family co-therapist—work with their families. The same interdisciplinary team that includes these clinicians and others follows the patient in transitions through various residences in the continuum of care—from hospital, to group residences in the main hospital building or elsewhere in Stockbridge and in the neighboring town of Lenox, to day treatment in patients’ own
apartments. The team works together over time to integrate a coherent view of the patient from different disciplinary perspectives.

In a treatment team review of John, a 30-year-old man with major depressive disorder, narcissistic personality disorder, and substance use disorder, team members presented differing views of him. Nursing staff found him aloof and arrogant, challenging hospital policy and avoiding their efforts to engage him. Therapeutic community staff noted John's efforts to help younger female patients in distress, often encouraging them to speak up in community meetings. The female therapist reported John's deepening engagement in therapy and his increasing recognition of his defensive devaluation of her in the context of his beginning exploration of his vulnerability and anxiety about potential abandonment by women he depended on. The social worker reminded the team of John's younger sister's suicide in his youth—in the context of his parents' divorce—and his mother's worsening breast cancer. The discussion put John's confusing combination of defensively arrogant devaluation of older women and his caretaking efforts toward younger women in perspective, helping nursing staff to persist in their efforts to engage John and to help him see the defensive nature of his withdrawal. John began to recognize the historical determinants for his problematic relationships and the repetition of these patterns in his relationships with community members and his therapist.

There is an activities program, described by Austen Riggs staff as a nonclinical “interpretation-free zone,” where patients take up the role of “student,” working in visual media, ceramics, woodworking, fiber arts, and a greenhouse. The program includes a Montessori preschool for children from the local community where patients may serve as volunteer aides. There is also a community theater where patients collaborate with members of the outside community and a professional theater director to put on plays.

Fran, a 36-year-old woman with an extensive history of childhood sexual abuse and multiple abusive adult relationships, was reading through a script for a planned play with a group of patients, Stockbridge residents, and the Austen Riggs theater director. Fran was to take the role of the wife of an army officer. In one scene, the woman dies and is carried offstage in the arms of the officer. As Fran read the stage directions, she gasped, saying, “I could never let a man touch me!” The theater director responded, “But you are dead!” Fran said, “Oh, that’s right,” and went on to do the play with great success, bringing her struggle around her experience into her psychotherapy.

The assessment phase culminates with a 2-hour case conference involving the entire clinical staff. Chaired by the medical director, this conference invites the patient to bring his or her own treatment focus and questions into an interview with the medical director and staff. Often the patient's questions dovetail with the issues raised in the assessment, so that the group can reach a formulation and treatment plan relevant to the patient's stated goals.

**Impact of the Setting**

The open setting and the staff’s reliance on patient authority meet and legitimize both autonomous functioning and dependency needs, including the need to belong. The structures of the program support patients’ strengths instead of focusing relentlessly on psychopathology:

- The open setting leans on patients’ capacities to manage themselves and, in a version of free association, gives patients room for and invites them to notice the choices they make each day.
- The therapeutic community authorizes patients’ leadership capacities in elected positions.
- The activities program—which formally removes them for periods of time from the patient role—offers these “students” a space for creative expression and the mobilization of strengths and capacities, conceptualized as separate from treatment.
- The culture of the center is organized around patients developing the potential to take charge of their treatment and their lives.
- The staff is organized around the understanding that patient resistance—their “acting out”—is a form of communication that requires translation.

All of these supportive and progressive structures serve to counterbalance the inevitable regressive pulls that are an aspect of intensive and deepening individual psychotherapy.

The treatment focuses on three sustaining areas: patient autonomy, meaning, and the importance of relationships. These patients communicate through projective identification and enactment the meaning of their painful life experience. In other settings, where staff authority is exercised to ensure treatment compliance, the patient may only be able to take up a passive role. This may unwittingly and paradoxically foster “treatment resistance,” when resistance to treatment is the only way left for a patient to exercise authority (Plakun 2006). Austen Riggs, through its freedom and structured examination of relationships, is designed to engage this difficulty through individual psychotherapy, family treatment, and the way individual transferences
are enacted through relationships with other patients and staff [E.R. Shapiro and Carr 1987]. In a therapeutic community of examined living, the resources are available to unpack these transferences, help tolerate them, and provide perspective [Muller 1999].

The community is constructed as a kind of theater in the round, a public opportunity for patients to live out—and begin to see—their difficulties with others. Managed by patients with staff consultation, the effort is to provide a structure for the translation of behavioral communication into words. Patient-led groups and a culture of ongoing interpersonal feedback communicate in different ways the impact that individual and group behavior has on others. For example, if a patient begins to get involved in an exclusive relationship with another patient, other patients inevitably feel envious and rejected. Public discussion of these reactions can illuminate how “pairing” is a group phenomenon [Bion 1961]. If a patient is involved in self-destructive behavior, others inevitably become frightened, guilty, and worried. Discussion of these responses helps the particular patient feel less isolated and desperate. Characteristic individual defenses, ordinarily invisible to the individual, become powerfully visible in community life. Individuals—beginning to see themselves in the eyes of others—have the opportunity to take up authority and responsibility with others in a kind of participatory democracy [Elmen-dorf and Parish 2007].

Individual Psychodynamic Psychotherapy

Individual psychotherapy focuses on listening, making sense of transference experience, and an unfolding receptiveness to the patient’s newly formulated experience [E.R. Shapiro 1982a]. Many patients with severe personality disorders manage their unbearable experience through the creation of painful and anger-filled relationships. Using the psychological mechanism of projective identification [Kernberg 1975, 1984; Klein 1946; E.R. Shapiro and Carr 1991] to protect themselves from their internal experience, patients unwittingly transform their internal self-critical torment into stormy and provocative behavior with others.

These patients have acute sensitivity to vulnerabilities and blind spots in their therapist’s character that they unconsciously use to evoke intense countertransferences [Prelinger 2004; E.R. Shapiro 2004]. Detection and careful unpacking of the countertransference enactments in staff discussions [Kernberg 1984; Plakun 2001, 2007; E.R. Shapiro 1982b; E.R. Shapiro and Carr 1987]—and eventually in individual psychotherapy—are a frequent part of the unfolding of the treatment. This process helps patients to see the role of their self-hatred, rage, guilt, and shame in producing desperate acts of self-abuse [e.g., cutting, burning, parasuicidal and suicidal behaviors] and angry, provocative interpersonal behaviors.

The treatment environment at Austen Riggs helps contain the impact of this behavior, translating it into a language that allows patients to gain perspective on their own unconscious motivations. However, the work proceeds with the evolving recognition that there are two fallible human beings in the consulting room when a therapist and patient meet. The therapy staff has opportunities to consult with colleagues [both on and off the treatment team] to help bear the intense countertransference of the work and find their own contribution to some of the struggles.

Psychodynamic psychotherapy in such a program focuses on character issues, paying particular attention to repeated maladaptive patterns of behavior. These are assumed to be behavioral communications (“acting out”) of inarticulate and painful childhood experiences. Interpretive work attempts to make sense of the problematic, usually negative, transferences that for many of these patients interfere with deepening relationships. The effort in psychodynamic treatment is to help patients put feelings into words, focusing on the contexts that evoke these behavioral patterns.

Family Treatment

A central context for the development of these difficulties for many of these patients is their families. Although parents do their best to love and support their children, they may also unwittingly bring into the family system powerful unconscious issues that can contribute to treatment resistance. Riggs invites families to participate in the treatment to help the patient and the clinicians both grasp the family’s perceptions of the patient’s development and begin to understand the family dynamics in which the patient’s symptoms are embedded [E.R. Shapiro and Freedman 1987]. These patients often have irrational roles in their families in which they are covertly invited through projective identification to carry problematic aspects of their parents’ past experiences [Berkowitz et al. 1974; Fromm 2004, 2006; E.R. Shapiro et al. 1975; Zinner and Shapiro 1975]. Family work aimed at unpacking these relationships places each member’s history in perspective, freeing the individual patient to consider his or her own life without the pressures of family needs [Schwartz 2007; E.R. Shapiro 1982b; E.R. Shapiro and Carr 1991; E.R. Shapiro et al. 1979].
Bill, a brilliant and obsessive 32-year-old man, had failed at multiple attempts to complete his education. Unable to sustain a job because of frequent arguments with his male superior, he had remained at home for years, isolated in his bedroom. Filled with hatred for his “cold, uncaring, and abusive” father, he insists that he remains home in order to protect his mother. On one occasion, confronted with his own inability to motivate his son, the father had said angrily to Bill, “I wish you’d never been born.” These family tensions and Bill’s periodic impulsive outbursts of rage led him to a potentially lethal suicide attempt that he survived only by accident.

When Bill was admitted to Austen Riggs, the therapist and social worker invited the family to a meeting. A rancorous argument between father and son erupted, requiring the therapist to intervene. Turning to the silent mother, the therapist asked, “How do you stand this?” The mother responded, “I’ve given up.” Both clinicians remarked to the mother that—given the potentially lethal outcome—she could not afford to withdraw. Recognizing how overwhelmed she was, they offered to assist her efforts to help her son decide on their softer sides. This intervention opened for father and son the possibility of revealing their shared vulnerabilities and the ways they had deeply hurt each other. Their underlying love for one another, and the relationship of the father’s angry withdrawal to his painful relationship with his own father, slowly emerged over months of work, allowing Bill some perspective on his family experience. His mother’s increasing competence in engaging this discussion helped Bill to recognize her strength, allowing him to begin to separate his needs from hers.

**Psychopharmacology**

Treatment resistance is often manifest in the patient’s relationship to the meaning of medication as much as in failure to respond to it. Mintz and Belnap (2006) described the practice of “psychodynamic psychopharmacology” with these patients, exploring the meaning that medications—and their side effects—have and the way these meanings may contribute to a “nocebo” (negative placebo) effect. These patients regularly experience caretakers as people likely to cause harm and react to prescribed medication as potentially harmful. This may interfere with medication adherence or may manifest as heightened sensitivity to even small doses. These adverse reactions evoke countertransference in the psychopharmacologist, contributing to the possibility of reactive irrational prescriptions that add multiple medications to respond to what is essentially a psychological problem. An interpretive treatment that includes team discussions between therapist and psychopharmacologist helps uncover such patterns; translating them into words can lead to a patient’s improved capacity to adhere to and tolerate potentially helpful medication regimens and engage more fully in treatment.

A second group of patients uses medications to replace relationships. Patients in this group experience their affects as “symptoms” and may use their clinical diagnoses and medications to reduce their responsibility for and engagement in life. Although patients in this group find medication helpful and necessary, they often do not appear to get better with them. Such patients at Riggs often find engagement in the therapeutic community to be an important stimulus for recognizing their own reactivity and responsiveness to others, opening the possibility of recognizing their affects as crucial information instead of pathological illness [Mintz and Belnap 2006].

**Management of Financial Resources**

In the traditional medical model, others—clinicians, managed care representatives, family members—ordinarily manage the financing of treatment on behalf of the patient. This leaves patients in a dependent position and creates an unfortunate incentive to do poorly in order to prove that treatment is needed. The wish to provide patients what they need in the face of resource limitations outside their control can lead clinicians to join patients in experiencing the “resource managers” in a shared projective way as bad, withholding, and unempathic (E.R. Shapiro 1997). Such collusion can both displace negative transference feelings from the therapy and interfere with rational collaboration around effective and appropriate use of inevitably limited resources.

Helping patients deal effectively with reality is an aspect of treatment. The cost of treatment and the limitations of financial resources must be faced in order to construct a secure and reliable treatment framework. Patients and families regularly have irrational emotional reactions to financial limitations, experiencing them through the filter of other limitations in life (emotional, security, health), making it difficult for them to think clearly. At Austen Riggs, a group of clinicians and business staff work with patients and families on resource limitations in order to help them grasp the actual financial facts and face the often conflicted feelings involved in using these funds (college funds, retirement assets, home equity loans) for treatment. When patients who value their treatment participate actively in discussions about the utilization of genuinely limited resources, they can emerge from a
passive position and discover an incentive to manage themselves better so they can step down to a less expensive level of care to extend their treatment. Facing the limitations of resources provides opportunities for both patients and families to come to terms with anger, guilt, and grief about painful reality (Plakun 1996; E.R. Shapiro 1997).

Suicidal and Aggressive Behaviors in Treatment

The open setting allows a broad range of freedom and maintains a clear distinction between behaviors that are potentially lethal and those that are not (Plakun 1994, 2001). Patients may well choose to engage in non-life-threatening superficial cutting and burning and eating behaviors as inarticulate ways of managing (and expressing) their feelings or defining their boundaries (Elmendorf 2007; Gunderson 2001; Sacksteder 1989a, 1989b). These are ordinarily managed by nursing staff’s bandaging or the local hospital’s suturing when needed. Clinical staff members work with patients to understand the feelings, fantasies, and relationship events that lie behind these acts—and their impact on others—but recognize the futility of trying to take on the task of preventing them. These efforts over time begin to communicate to the patient that behavior is communication, often communication about unbearably painful feelings.

When self-destructive behaviors threaten the patient’s life and the continuity of the treatment, the therapist immediately addresses the issue in relation to the alliance. Among other things, a suicide plan is a decision on the patient’s part to end the treatment. It therefore reflects problems in the treatment relationship that must be explored, including, potentially, the therapist’s unwitting contribution to that decision (Clarkin 2001, 2006; Kernberg 1984; Plakun 1994, 2001). Should a patient act with actual suicidal intent, the clinician assumes, in keeping with the clearly negotiated terms of admission, that the patient has chosen to end treatment at Austen Riggs. The patient is ordinarily then transferred elsewhere—to a locked setting—for emergency medical and psychiatric management. Often the patient returns to the center when safe, at which point the focus of the work of the patient, therapist, and treatment team is on carrying out a consultation over the next several weeks to determine why the patient chose to end treatment by ending his or her life, how the therapist may have unwittingly played a role in that choice, what the patient has learned in the event, whether the patient wishes to and is able to return to the kind of alliance needed to do the work, and whether the treatment can continue or has been damaged beyond repair. This process is often a powerful intervention that, when successful, has been associated with good outcome (Plakun 1991).

If patients engage in dangerous behaviors that suggest they are unable to adhere to the terms of the negotiated treatment alliance by keeping themselves safe, but they have not endangered their lives, they may step up to an open inpatient level of care at the center for relatively brief periods. During this time they negotiate with nursing staff the limits of their freedom (for example, turning in car keys or not leaving the hospital grounds) that make clinical sense while their treatment focuses intensively on monitoring their safety and determining whether they can repair their treatment alliance or need treatment elsewhere. The center does not use any restraint or seclusion unless acute psychotic or impulsive suicidal behavior requires temporary restraint prior to transfer. In such circumstances the police are called to help staff manage the situation. This happens rarely, because the culture of the community ordinarily helps patients turn to staff or to one another before they lose control.

Research

Wallerstein (1986) and Gabbard et al. (1999) presented cohort studies of patients treated at the Menninger Clinic suggesting the value of extended treatment for similar patients. Chiesa et al. (2004) provided evidence that extended psychodynamic residential treatment with a continuum of care was an effective treatment for patients with severe personality disorders, many of whom had significant Axis I comorbidity.

The Austen Riggs Center has been involved in studying this patients: population since the 1950s, when Robert Knight (1954) wrote the seminal paper on borderline patients. Psychoanalytic theoreticians including Erik Erikson, David Rapaport, and Roy Schafer developed the field of ego psychology at Austen Riggs in the 1950s by working with this patient population (Erikson 1956, 1964a, 1964b; Rapaport 1959, 1967; Schafer 1999). Otto Will (1980) deepened his studies of schizophrenia at Austen Riggs, and several studies in the 1970s and 1980s focused on the outcomes of patients in treatment at the center (Blatt and Ford 1994; Plakun et al. 1985).

Recognizing that it had an opportunity to study this group of patients more intensively and in more
depth than colleagues could in other settings—and that the clinical data included the family and social context—Austen Riggs decided that it had an obligation to the larger field. In 1994 it created the Erikson Institute for Education and Research to continue this learning and apply the concepts emerging from this work to other settings. Since that time the center has been engaged in the follow-along study described earlier, examining the progression of 226 patients (51% of the available sample) at 6-month intervals for 6–10 years. The hope is to learn about the natural progression of this difficult-to-treat group of patients.

The first paper from the study reports on the issue of suicide, showing an overall rate of completed suicide of 2.5% in discharged treatment-refractory patients (examining 100% of the patients discharged from Austen Riggs during the study period, including those who did not elect to participate in the study). Long-term results (a mean of 9 years of follow-up) suggest that study patients ultimately improved significantly in terms of suicide-related symptoms (Perry et al., in press). The data indicate that suicidal behavior remitted first, followed by self-destructive behavior, whereas suicidal ideation persisted longer. The findings are consistent with the hypothesis that this multimodal treatment approach helps patients with previously treatment-refractory illness, many of whom struggle with suicide, to begin to move from behavior into language to manage their painful experiences as they begin the process of taking charge of their lives.

In addition, the Erikson Institute has begun to apply the learning from Austen Riggs to some of the problems of the larger society, ranging from administration (E.R. Shapiro 2001a, 2001c), to the trans-generational transmission of trauma (Fromm 2004, 2006), to citizenship (E.R. Shapiro 2003, 2005; E.R. Shapiro and Carr 2006).

**Conclusion**

There is a subset of patients with treatment-resistant illnesses, often with comorbid mood and personality disorders and other comorbid disorders, for whom “resistance” to treatment is organized around unconsciously determined difficulty engaging in a treatment alliance in which they can find their own voice and authority. Recognizing that the alliance is the foundation that supports the treatment, the Austen Riggs Center has constructed a focused residential approach to these patients. The center places patients in charge of themselves in an open setting in which authority is negotiated between staff and patients rather than assumed by staff. The negotiated agreement is to explore the patient’s mind and the meaning of behavior and relationships. The patient’s deviations from that agreement and the related acting-out behavior—when not threatening the patient’s life or the treatment of others—are seen as opportunities for learning, because these patients tend to communicate their difficulties through behavior.

In this residential setting, attention to both the meaning of medication and its effects helps maximize its utilization. Individual psychodynamic psychotherapy is designed to help the patient focus on a deepening intimate relationship in which aspects of the past are relived and translated into language. Because these patients tend to split their transferences—often by idealizing one relationship and devaluing another—the capacity of the staff to sustain and examine the patient’s relationships with all members of the treatment team allows the possibility of showing the patient how this phenomenon occurs while offering the possibility of re-integrating these split relationships within the individual therapy. At the same time, the experiences of examined living and constant feedback from a therapeutic community help the patient translate his or her behavior into language and meaningful experience. Concurrent family work gives the patient perspective on the developmental context of disturbance and helps to mobilize family relationships and resources for the treatment.

The constellation of resources available at Austen Riggs adds to contemporary general psychiatric treatment a diverse range of psychosocial treatments integrated by a psychodynamic understanding of personality functioning. These patients with treatment-resistant conditions may also be conceived of as delegates of their families and social contexts who are carrying potential learning about the unbearable difficulties of the interpersonal world and the larger society (Elmendorf and Parish 2007; Fromm 2004, 2006; E.R. Shapiro and Carr 1991). Far from being doomed to chronic crisis management, the evidence indicates that such patients are treatable and capable of finding their voices and a role in society.

Given the substantial problem of treatment resistance, it is important that this and similar comprehensive, integrative, psychodynamically based residential treatment centers continue to be available as part of the standard of care for these patients, who have so much to offer and from whom we have so much to learn. In addition, the insights developed
from the intensive clinical work in this national referral center are applicable to other settings, including outpatient settings.

Patients with treatment-resistant illnesses emerge from our increasingly complex and stressful social contexts. Successful treatment of these illnesses requires a serious clinical commitment from the profession both to recognize how these struggles develop and to provide a sufficient biopsychosocial treatment space so that these patients might find their way to rejoin the larger society.

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