

Research and Teaching Statement: Lorna Smith Benjamin

The domains of Research, Teaching and Clinical Service are 3 sides of a pyramid of clinical science, and so I'd like to address them together. For me, the connection among these domains inheres in shared ways of knowing (scientific methodology), and in the potential for near term as well as longer term beneficence. Each involves careful observation, some kind of hypothesis (theory) that both guides the observations and in turn is guided by them. Each domain seeks to understand and enhance human welfare. The scientist usually focuses on discovering more about the ways of nature; the clinician focuses on helping a particular patient or client; the teacher is concerned about imparting knowledge to specific students. Such distinctions can fade, as when a clinician and patient work together as scientists to gather and understand personal data; or when a student with a "naïve" but quintessentially relevant question teaches a teacher something new. Because importance of all three perspectives, and the thin boundaries among them, my preference is to try to make each domain address the perspective of the other two, no matter what the current focus. Once, I wrote about some aspects of overlap between research and practice [Benjamin, L.S. (2000). Scientific discipline can enhance clinical effectiveness. In S. Soldz & L. McCullough (Eds.) Reconciling empirical knowledge and clinical experience. The art and science of psychotherapy. Washington, D.C.: American Psychological Association, pp. 197-219.] In accord with the belief that teaching, research and practice can be closely knit, I have devoted time about equally among research, teaching and practice, and regularly use one to inform the other two.

Early in my career, I wanted to better define clinical concepts so they could be subjected to research analysis. Being impressed with the fact that what people talk most about during psychotherapy is their relationships with self and others, I developed Structural Analysis of Social Behavior (SASB) to provide an objective measure of the content and process in psychotherapy. This model and its associated technology assesses rater views of self and other, and offers a means of "checking" these perceived patterns with object observer judgments expressed in the same metric. Comparison of perspectives and connections between psychopathology and the effectiveness of particular interventions can be very useful. After developing the SASB, I (and others) used it to better understand psychopathology in general, and personality disorder in particular. The result was Benjamin, L.S. (1996/ 2003 paperback) Interpersonal diagnosis and treatment of personality disorder, Second edition. New York: Guilford Press. The next stage was to apply what had been learned in using SASB methodology to study psychopathology, to psychosocial treatments of mental disorder. Results appeared in Benjamin, L.S.(2003/ 2006 paperback), Interpersonal Reconstructive Therapy (IRT): an integrative personality-based approach to complex cases. N.Y.: Guilford Press. The SASB, the study of personality disorder, the development IRT – which uses a case formulation to optimize choices of interventions from major known psychotherapy approaches- were

always tied to clinical practice, and to concrete data from clinical narratives. SASB and IRT were implicitly (at first) and explicitly (later) represented in my practice and teaching: of psychiatric residents and psychology interns while at the University of Wisconsin Medical Center Department of Psychiatry (1971 to 1986), and of Psychology students at the University of Utah. My research now centers on IRT, uses SASB, and has immediate, practical clinical usefulness.

Since “retiring” to half time in Psychology I have worked exclusively in the IRT clinic at the University of Utah Neuropsychiatric Institute (UNI), teaching psychology graduate students (some hospital staff; and practitioners; and teachers and researchers at other institutions) about using IRT to work with the very difficult CORDS population. The choice of CORDS is significant. They are severely disturbed, suffer enormously, and usually are dysfunctional and dangerous to themselves or others; consequently they are stressful for and costly to themselves, their families and the mental health system. There are no known effective approaches to treat them, and they are routinely excluded from research studies designed to establish whether a treatment is effective or not. Here is a description of CORDS taken from my recent submission (with Kenneth Critchfield as Co-PI) to NIMH for support of our clinical research at UNI..

Subjects now enter protocol as inpatient referrals to the IRT clinic. After discharge, some continue for long term IRT outpatient treatment with graduate student IRT trainee therapists. The service and educational functions of the clinic support our opportunity for research; we do not suggest this sample would qualify for an RCT. Instead, we view this as a naturalistic developmental study of difficult patients, whose treatment resistant variants of disorder are believed by referring physicians to be associated with personality disorder. With excellent support from physicians, hospital staff, and patients, we have elicited almost 100% participation in the research after the inpatient consultative (intake) interview. Research results allow us to better characterize our population (pp. 14-15) and use those results to select subjects in a future RCT. For example, data from intakes over the 2 years we have had permission to search past medical records yield an average number of lifetime psychiatric hospitalizations of 4.1. That number is a dependent variable; if we used it as an independent variable in a future RCT, we would require participants to have 4 or more lifetime hospitalizations. Results to date define our population as CORDS (individuals who have disorders associated with the follow features: Comorbid, Often Rehospitalized, Dysfunctional, Suicidal). Specifically, to date that means (1) lifetime hospitalizations (4.1) (2) lifetime suicide attempts (2.4 attempts); Current Axis I comorbidity according to the medical record (2.3 disorders); Current Axis II comorbidity (2.1) according to the SCID-II interview (First, Spitzer, Gibbon, Williams, & Benjamin, 1997); dysfunctional as indicated by GAF ratings by the admissions officer (average =25). For a future R-01 RCT study, we would use data from this developmental study to set minimum values of CORDS descriptors for admission to the RCT (pp. 13-15).

D-1-e-(3). Our population includes individuals that typically are excluded from RCT trials. It is easy to find published RCTs that excluded CORDS -like subjects. Axis I comorbidity, specific personality disorders, frequent rehospitalizations, suicidality, drug and alcohol abuse and dependency, eating

disorders, are examples of features we accept that normally are excluded. Our exclusionary rules include only: English as a primary language, age (18 -70), chronic schizophrenia, central nervous system and endocrine or other forms of non psychiatric medical disease clearly accounting for presenting complaints, and those currently receiving ECT. Our IRT clinic addresses an area of great clinical need.

Our developmental research protocol involves assessing nearly every aspect of our IRT service and educational clinic. Because of the complex and dangerous nature of the population, supervision (education and service) is time intensive and N's are small. This requires us to be creative in research definitions of the population itself; in developing measures of effectiveness; in describing objectively the nature and implementation of the complex treatment approach. The IRT book is used consistently in supervision. A counseling student on the IRT team is doing his dissertation on training our IRT students by using educational technology for training complex skills that were developed in teaching pilots. To detail understanding of the complexity (and atypicality) of the research protocol, here is the specific aims section of the current grant application:

A. Specific Aims

*Interpersonal Reconstructive Therapy (IRT) was developed primarily within a referral practice for psychiatric inpatients who have had an average lifetime number of about four prior hospitalizations, usually for suicidality. In the opinion of referring physicians, patients have complicated combinations of disorders that have not responded well to standard treatment because there might be "Axis II involvement." Almost all of our referrals would be excluded from standard RCT psychiatric drug study protocols (and the equivalent Empirically Supported Therapies, EST, for psychotherapy) because of their high comorbidity, records of chronic suicidality, frequent hospitalizations, prior nonresponsiveness to the treatment being studied, plus specific diagnostic exclusions such as drug or alcohol abuse or dependence, bipolar, obsessive compulsive or eating disorders –all of which, we accept. The severity of their conditions often renders them nonfunctional at the time of intake. **We call our population CORDS (meaning individuals who have disorders associated with the following features: comorbid, often rehospitalized, dysfunctional and suicidal). This may be a subset of the SMI (Severely Mentally Ill population).** The research literature has consistently shown that Axis I disorders that are comorbid with personality disorders are likely to be more severe, and longer lasting (Shea, Widiger & Klein, 1992; Bender et al, 2001) and more difficult to treat (Tyrer, Seivewright & Johnson, 2004; Diguier, Barber & Luborsky, 1993). A large percentage of our referrals are labeled and qualify for Borderline Personality Disorder (BPD) according to SCID-II (First, Spitzer, Gibbons, Williams & Benjamin, 1997). However, according to Benjamin's (1996) necessary and exclusionary conditions, many are more appropriately classified as Passive Aggressive (PAG) or Obsessive Compulsive (OCD) personality disorder. Referrals to the IRT clinic are supported by the hope that consultation, perhaps followed by treatment with focus on personality, could help the CORDS population become more amenable to standard interventions for their comorbid Axis I disorders. Following the consultation, there is a follow up inpatient treatment with Psychology graduate student IRT trainees that consolidates understanding of the case formulation and begins to work on its*

implications. When desired by the inpatient treatment team, the patient, and the IRT team, patients continue on with their IRT trainee therapist for longer term outpatient IRT treatment.

The main manual for IRT (Benjamin, 2003) represents a formalized eclecticism that resulted from efforts to codify and integrate what has been helpful with these repeatedly hospitalized patients likely to have personality disorder. IRT runs concurrently with appropriate independent treatments (e.g., medications), and offers specific instructions for when and how to draw from psychodynamic, cognitive behavioral, client centered, interpersonal, humanistic/ existential and other psychosocial treatment approaches. The case formulation method details what must be targeted in treatment for each individual patient. Consistent use of it optimizes interventions on a moment to moment basis. IRT is described in greater detail in section C.

The primary aim of this proposal is to prepare for a future R-01 application that would use an RCT design to test effectiveness of Interpersonal Reconstructive Therapy (IRT) with the CORDS population. The **specific aims** are to: (1) increase and better assess reliability of the IRT case formulation methods; (2) further develop reliable measures of treatment fidelity (adherence/competence). These (a) will help us train adherent IRT therapists, (b) will assure we can identify treatment adherent therapists for a future RCT, and (c) will be a component of one of six measures of effectiveness under aim #3. (3) Obtain preliminary measures of effectiveness of IRT. These will include: (a) Assessments of response to treatment in terms of % subjects who showed adequate levels of relevant symptom change (b) Assessments of remission rates (c) Reports of any significant deterioration. (d) Assessments of effect size. (e) Identification of significant pre-post changes and (f) reports of significant associations between treatment fidelity and outcome.

The specific aims here illustrate how closely teaching, research and practice are integrated in the IRT clinic. I feel very fortunate to have been supported by Psychology and by UNI, as well as by my close colleagues, Ken Critchfield and Thomas Woolf, in this effort to bring it all together in this way.