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PSYCHODYNAMIC APPROACH AS A CREATIVE FACTOR IN PSYCHOPHARMACOTHERAPY

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SUMMARY

The treatment of psychiatric disorders often consists of a combined approach that integrates both pharmacotherapy and psychotherapy. Unfortunately, psychiatric texts and the educational process in psychiatry training do not adequately address the combined approach. There is a lack of information concerned with the psychological aspect of prescribing medications. This is striking since many patients require both treatments. There is an inevitable psychological aspect of the administration of medication in psychiatry, and the meaning ascribed to the prescription of drugs has an impact on doctor-patient relationship. Understanding the psychodynamic issues is crucial for the success of psychopharmacology.

Psychodynamic psychopharmacotherapy represents an integration of biological psychiatry and psychodynamic insights and techniques. This approach recognizes that many of the core discoveries of psychoanalysis are powerful factors in the complex relationship between the patient, the illness, the doctor, and the medications.

Scientific pharmacotherapy is, as it should be, based upon patients' responses to treatments of specific target conditions. Enduring personality traits are being increasingly incorporated as targets for pharmacotherapy. However, in the real world of psychiatric practice we see that transference issues and a patient's character or set of personality traits have a greater impact on the selection, dosage, tolerability, and treatment outcome than is generally recognized or admitted.

In contemporary psychiatry, a psychodynamic perspective must be preserved. Without it, meaning will be lost, and both diagnostic understanding and informed treatment planning will suffer.

Key words: *psychodynamic psychotherapy – psychopharmacology - psychodynamic psychopharmacotherapy - creative psychopharmacotherapy*

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INTRODUCTION

Over the last 30 years psychiatry and psychoanalysis have diverged substantially. Psychiatry has become rich in methodology but conceptually limited, with a trend towards biological reductionism. Psychoanalysis has remained relatively limited in methodology, but conceptually rich. The rich methodology of psychiatry has led to major contributions in discovering complex gene-environment interactions, the importance of early adversity, and to the recognition of serious problems posed by treatment resistance. However, psychiatry's biologically reductionist conceptual focus interferes with the development of a nuanced clinical perspective based on emerging knowledge that might help treatment-resistant patients become treatment responders. Recognizing the problem of treatment resistance prompts the need for psychiatric practice to reconnect with the conceptual richness of psychoanalysis in an effort to improve patient care. Psychodynamic psychiatry is defined as the intersection of psychiatry and psychoanalysis where this reconnection can occur (Plakun 2012).

There is an inevitable psychological aspect of the administration of medication in psychiatry, and the meaning ascribed to the prescription of drugs has an impact on doctor-patient relationship. Having an understanding of a patient's psychodynamic arrangement is pertinent to a rational selection of psychopharmacology. Psychodynamic psychopharmacology represents a synthesis of biological psychiatry with psychodynamic insights and techniques. This approach recognizes that many of the core discoveries of psychoanalysis (unconscious, conflict, resistance, transference, defense, etc.) are powerful factors in the complex relationship between the patient, the illness, the doctor, and the medications. Although patients ask for help, many are themselves conflicted about getting well if their illness has created some conscious or unconscious benefit. If a patient is not ready to change, it is unlikely that a medication, however potent, will produce a therapeutic effect. Psychodynamic psychopharmacotherapy combines a rational approach to prescribing medications with methods that help identify obstacles that interfere with the effectiveness of medications.

Scientific pharmacotherapy is, as it should be, based upon the results of patient responses to treatments of specific target conditions. Enduring personality traits are being increasingly incorporated as targets for pharmacotherapy. However, in the real world of psychiatric practice we see that transference issues and a patient's character or set of personality traits have a greater impact on the selection, dosage, tolerability, and treatment outcome than is generally recognized or admitted. A new field of psychodynamic pharmacotherapy is encouraged along with a culturally-informed attitude to prescribing medications (Forrest 2004). The relevance of these issues demands that practitioners be mindful of psychodynamic factors and maintain dialectics in clinical practice (Li 2010).

Collaborations between psychiatrists acting as medication consultants and therapists providing psychotherapy are an increasingly common form of treatment. Complex transference and countertransference reactions can arise in these "therapeutic triangles." Risks include splitting by the patient, conflicts between the two kinds of therapy, and premature termination of either the psychotherapy or pharmacotherapy. There are typical transference and countertransference reactions that can lead to these problems. A collaborative approach must be based on a mutual respect, trust, and openness that, along with an awareness of typical transference and countertransference issues, can increase the likelihood of a positive treatment outcome (Bush & Gould 1993).

TREATMENT RESISTANCE, NONADHERENCE, AND NOCEBO

Treatment-resistant patients frequently require treatment modalities beyond combined psychopharmacology and individual psychotherapy. They often require a team effort to manage crises, contain anxiety, and create a psychological space for examining the impact and meaning of their behavior.

Mintz and Belnup (2006) explored the phenomenon of treatment resistance in relation to medications. They proposed and defined a discipline of "psychodynamic psychopharmacology," described its philosophical underpinnings and offered technical recommendations for the psychodynamic treatment of pharmacologic treatment resistance. These authors suggest that meaning and interpersonal issues have a major role in achieving a positive pharmacologic treatment outcome, and suggest that many patients are "treatment-resistant" because an appreciation of the patient's dynamics is not incurporated into an understanding of repeated treatment failures (Mintz & Belnap 2006). They also propose that psychodynamic psychopharmacology advances the overall clinical effectiveness of medications in treatment-resistant patients by integrating a psychodynamic appreciation of the patient with a psychopharmacologic understanding.

From a psychodynamic point of view, pharmacological treatment resistance has different underlying dynamics and requires different kinds of interventions. Patients that are resistant to medication may be subject to conscious or unconscious factors that interfere with the desired effect of medications. This can take the form of non-adherence or nocebo response.

In 1905 Freud described the psychodynamic concept of resistance and concluded that many patients were unconsciously reluctant to relinquish their symptoms or were driven, for transference reasons, to resist the doctor. The same dynamics may apply in pharmacotherapy and may manifest as treatment resistance. When symptoms constitute an important defense mechanism, patients are likely to resist medication effects until they have developed more mature defenses or more effective ways of coping. Defense mechanisms play an important role in the dynamics of resistance and vice versa (Vlastelica et al. 2005, Vlastelica 2010).

Patients who are not resistant to symptom reduction may nonetheless be motivated to resist the doctor due to transference, and such patients often negotiate the medication, dosing, timing of medications, etc. (trying to “keep control” of the “untrustworthy” doctor, managing their own regimen by taking more or, more commonly, less than the prescribed dose). As noted before, if these patients cannot resist the doctor's orders, their bodies may unconsciously do the resisting for them, which leads to nocebo effects. Classical psychoanalytic theory, with its emphasis on concepts of resistance, transference, and countertransference, has shed some light on the reasons for nonadherence and helped guide clinicians who work with these patients. Some helpful psychodynamic concepts include a failure of clinicians to empathize with their patients which is driven from an unconscious need to be protected from their distress, and clinicians' use of denial, rationalization, and isolation of affect. Nonadherence to treatment represents one of the most prevalent and important challenges in the practice of psychiatry. Alfonso (2011) emphasizes better understanding of nonadherence within the paradigm of attachment. Psychodynamic theory provides a framework that could be helpful in clarifying our understanding of nonadherence. Particularly, contributions from attachment theory and research have led to a deeper understanding of nonadherence. Dismissing attachment behaviors in our nonadherent patients can help us reframe our psychotherapeutic work. Wallin (2007) describes the process of therapeutic interventions with dismissing individuals as “moving from isolation to intimacy.” In the early stages of treatment, he encourages a keen awareness of subtle affective cues and nonverbal communication, and a judicious sharing of countertransference to help patients be comfortable in letting others in and become collaborators in treatment. The dynamics of power struggles and control need to be clearly understood by the therapist, and a warm, collaborative, and cooperative stance is preferred to an authoritarian and detached attitude (Wallin 2007).

Psychiatrists who operate from either a dogmatic psychotherapeutic paradigm or a psychopharmacological paradigm are not allowing themselves access to the patient as a whole. Psychodynamic psychopharmacotherapy in this view accepts the application of Stein's "brain-mind" concept, offering explanations for many dilemmas, particularly for treatment resistance or nonadherence (Stein 2008, Vlastelica et al. 2011).

A PERSPECTIVE OF PSYCHODYNAMIC PSYCHOPHARMACOTHERAPY

Psychodynamic psychopharmacology creates opportunities for a richer and more effective understanding of

the entire therapeutic process, in which pharmacotherapy is applied in the treatment of mental disorders. It is a way of thinking about the pharmacotherapy of mental illness that incorporates both pharmacological and psychodynamic knowledge in a practical clinical approach and treatment-related decision making (Murawiec 2009).

The treatment of psychiatric disorders often consists of a combined approach that integrates both pharmacotherapy and psychotherapy. Unfortunately, psychiatric texts and the educational process in psychiatry training do not adequately address the combined approach. There is a lack of information concerned with the psychological aspect of prescribing medications. This is striking since many patients require both treatments. Another important artificial separation is the lack of integration of psychological knowledge in the understanding of psychological and physical effects of pharmacotherapy. The proposition of a new discipline, psychodynamic psychopharmacology, by D. Mintz and B. Belnap offers not only a new discipline but also practical recommendations for the psychodynamic treatment of pharmacologic treatment resistance (Murawiec 2008).

It is very important to make synthesis of psychodynamic and neuroscientific data because of similar patterns (i.e. analogies) that exist between them. Many neuroscientific discoveries have just reaffirmed the psychodynamic postulates (e.g. the concept of “attachment” and the role of the limbic brain system). A purely psychological psychodynamic view, lacking this medical perspective, fails to model human mental processes and reflects problems with artificial intelligence models that do not reflect the complexities of the brain. The pathological reactions that we address in psychiatry and neuropsychiatry interfere with and thereby reveal parallel processing in (1) analogical and metaphorical thinking; (2) reduplication, redundancy, and repetitiveness; (3) self, person, and environmental recognition, including transference processes; (4) approximation and statistical inference; (5) spatial and motor control; (6) affect, perception of sensations and sexuality; (7) projective mechanisms; and (8) problem solving by optimization, vector summation, and the mutual interaction of interconnected agencies (Forrest 1991). Medical psychoanalysts, who comprehend dynamic and brain mechanisms and can describe them in terms that refer to both domains and their interaction, should find an increasing theoretical and practical convergence of their work. More than in the past, the practice of the dynamic psychiatrist is modeled after that of the internist - a physician who integrates into his/her clinical work the current understanding of the function of the brain. The dynamic psychiatrist actively participates in the resolution of a given symptom picture and fosters improvement of the patient's personality structure to maximize functioning (Olarte 2009).

According to Groleger (2007), in every illness both mind and body can be affected to different extents. It is difficult to discern which manifestations of an illness are rooted in the body and which in the mind, even in the seemingly obvious comparison of a person suffering a broken leg with a person suffering an acute stress reaction. For this reason, it might be an over-simplification to differentiate sharply between biological and psychological therapies. Evidence shows that psychotherapy influences the biology of the brain, and that pharmacotherapy influences the psychological, social and developmental dimensions of the individual as well as their overall functioning and well-being. In an era where medicine discovered psychology and psychiatry discovered biology, debates and divisions that have stemmed from past dualisms should end. Every practicing physician, regardless of their medical discipline, uses in their everyday practice both biological and psychological approaches to help successfully treat the patient (Groeleger 2007).

In contemporary psychiatry, a psychodynamic perspective must be preserved. Without it, meaning will be lost, and both diagnostic understanding and informed treatment planning will suffer (Gabbard 1992).

Even before the "decade of brain", some psychotherapists claimed that pharmacotherapy could be integrated into the process of psychotherapy by construing it as one of many interventions available to the physician-psychotherapist, rather than maintaining a strict dichotomy between verbal and pharmacological techniques. Each set of interventions influences cerebral electro-chemical processes and each takes place within an evolving therapeutic relationship which proceeds through different stages. One of the major challenges to current clinical psychiatry is the development of firm guidelines for combined therapy (Beirman 1981).

CONCLUSION

Understanding psychodynamic issues is pertinent to prescribing psychopharmacotherapy, and the psychodynamic approach works as a creative factor in psychopharmacotherapy. In contemporary psychiatry, a psychodynamic perspective must be preserved. Without it, meaning will be lost, and both diagnostic understanding and informed treatment planning will suffer.

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