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EFFECTS OF MEANING OR PSYCHODYNAMIC PSYCOPHARMACOTHERAPY

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SUMMARY

Despite advances in psychiatry, treatment outcomes are still a big problem, and are not always substantially better than it was in the past time. Treatment resistance remains a serious psychiatric problem. One of the reasons for that is that the pendulum has swung from a psychodynamic framework to a biological one, and the impact of meaning (i.e. the role of psychodynamic and psychosocial factors in treatment-refractory illness) has been relatively neglected. Dynamic factors in psychopharmacology play a pivotal role in pharmacological treatment responsiveness. There is a small but impressive evidence base that shows that psychological and interpersonal factors play that role. Psychodynamic psycho pharmacotherapy combines rational prescribing with tools to identify irrational interferences with effective use of medications, i.e. to resolve the problems of the pharmacological-treatment resistance. Psychodynamic psychopharmacology represents an integration of biological psychiatry and psychodynamic insights and techniques.

Key words: *psychodynamic psychopharmacology – placebo - nocebo – transference-therapeutic alliance – resistance – psychotherapeutic frame*

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INTRODUCTION

Psychodynamic psychopharmacology explicitly acknowledges and addresses the central role of meaning and interpersonal factors in pharmacological treatment (Mintz & Belnap 2006). This approach recognizes that many of the core discoveries of psychoanalysis (the unconscious, conflict, resistance, transference, defense) are powerful factors in the complex relationship between the patient, the illness, the doctor, and the medications. In many cases, these factors are concordant with treatment and do not need to be addressed in order for treatment to be effective. However, in patients who are treatment-resistant, it is likely that psychodynamic factors (that may be unconscious) are deeply at odds with therapeutic goals.

Dynamic factors in psychopharmacology often play a pivotal role in pharmacological treatment responsiveness. There is a small but impressive evidence base that shows that psychological and interpersonal factors are the ones that play that role.

Psychodynamic psychopharmacotherapy provides little guidance about what to prescribe; instead, it helps prescribers know how to prescribe to improve outcomes, and in that way represents an integration of biological psychiatry and psychodynamic insights and techniques.

PSYCHODYNAMIC PSYCHOPHARMACOLOGY

A series of meta-analyses shows that, although antidepressant medication are effective, the placebo effect somewhere accounts for between 76% and 81% of treatment effectiveness (Kirsch & Sapierstein 2009, Kahn et al. 2000). Placebo does not mean imaginary or untrue, it produces real, clinically significant, and objectively measurable improvement. Placebo responses produce measurable changes in brain activity that largely overlaps medication-induced improvements (Mayberg 2002). The patient's desire to change and a positive transference to the doctor and his/her medication can mobilize profound self-healing capacities.

Although patients ask for help, many of them are 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. For example, there is a study that found, in placebo-controlled trial, that those patients who received a benzodiazepine for anxiety and who were highly motivated to change had the most robust response. However, placebo recipients who were highly motivated to change had a greater reduction in anxiety than patients who took the active drug but were less ready to change (Beitman et al. 1994). Readiness to change is powerful determinant of treatment effectiveness, sometimes more potent than type of therapy.

Freud in 1912. noted that positive transference (consisting also of such things as the patient's belief in the doctor's salutary intentions, the wish to use the doctor to get better, and the desire to win the doctor's love or esteem by genuinely trying to get better) was, in the end, a key factor in the patient's ability to overcome symptoms. Freud's positive transference we can call today the therapeutic alliance, and it is one of the most potent ingredients of treatment (Blatt & Zuroff 2005). There is a large placebo-controlled, multicenter trial of treatment of depression that showed that patient were

most likely to respond when they received the active drug but had a strong therapeutic alliance (Krupnick et al. 1996). Patients who received placebo and had a strong therapeutic alliance had a significantly better therapeutic response than patient who received an antidepressant but had a poor therapeutic alliance.

Finally, these three groups of researches (placebo response, readiness to change, therapeutic alliance) examined the relative effectiveness of biologically active aspects of the medication. They show that effects of meaning are at least as potent as effects of biology.

Just as positive transference to the doctor or drug lead to positive responses, negative transference are likely to lead to negative responses, and these patients are prone to nocebo responses (Hahn 1997). The obverse of the placebo response, nocebo responses occur when patients expect (consciously or unconsciously) to be harmed. Many of them who experience intolerable adverse effects to medication are nocebo responders, and many of them become treatment-resistant.

Therapeutic action occurs more profoundly when the therapist – rather than attempting to dissuade the patient from his or her own felt experience - seeks instead to locate the patient's vantage point and its inherent legitimacy (Schwaber 2009). The transference, then, is understood as a perceptual experience to illuminate, not a distortion or projection to alter. It is striking how outer behaviors and symptoms may abate ideations about the therapist's mal intent or lack of care. In that light, psychopharmacology should concern about medication.

PHARMACOLOGICAL - TREATMENT RESISTANCE

From a psychodynamic point of view, pharmacological-treatment resistance has different underlying dynamics and requires different kinds of interventions - patients may be seen as resistant to medication or resistant from medication. The first ones, who are resistant to medications, have conscious or unconscious factors that interfere with the desired effect of medications. It takes form of nonadherence but also in nocebo response.

In contrast, resistant from medications are eager to receive the medication (or some benefit that the patient attributes to the medication) and although pills may appear to relieve symptoms they do not contribute to an improvement in the patient's quality of life.

Resistance to medications and resistance from medications are not mutually exclusive, and many patients present with both dynamics.

Freud in 1905. 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 important role in dynamics of resistance and vice versa (Vlastelica et al. 2005). Patients who are not resistant to symptom reduction may nonetheless be motivated to resist the doctor, for transference reasons, and such patients often negotiate the medication, dosing, timing of medications etc. (trying to „keep control" over the „untrustworthy" doctor, managing their own regimen by taking more or, more often, less than the prescribed dose). Needless to say, not taking a therapeutic dose, lessen the chances of therapeutic response. As noted before, if these patients cannot resist the doctor's order, then their bodies may unconsciously do the resisting for them, which leads to nocebo effects.

Treatment-resistant patients do not function better with pharmacotherapy; in fact, some of them get worse. A psychodynamic psychopharmacologist is mindful that there are countless ways these medications may serve countertherapeutic and/or defensive aims.

ELEMENTS OF PSYCHODYNAMIC PSYCHOPHARMACOTHERAPY

Psychodynamic psychopharmacotherapy provides little guidance about what to prescribe; instead, it helps prescribers know how to prescribe to improve outcomes. Psychodynamic psychopharmacology/ psychopharmacotherapy represents an integration of biological psychiatry and psychodynamic insights and techniques.

There are 6 principles for psychodynamic pharmacological practice with treatment-resistant patients (Mintz 2006):

1. *Avoid a mind-body split*: A psychodynamic psychopharmacotherapist completely refuses mind-body dualism, of course. Feelings, ideas, experiences, relationships... all that change the structure and function of the brain, just as the state of the brain influences experience. A psychodynamic psychopharmacologist considers that a positive or negative medication response may be not only a direct action of the pill, but mediated by the meanings the patient attaches to the pill as well. Mind-body integration also means that psychotherapy and psychopharmacology will need to be well-integrated so that psychopharmacological interventions facilitate the psychotherapy and so that the therapy helps the patient become conscious of psychological sources of pharmacological-treatment resistance. Effective psychopharmacological interventions to treatment nonresponse might include an increase in frequency of appointments rather than an increase in medication dosage (Ankarberg & Falkenström 2008).

2. *Know your patient*: The central tenet of psychodynamic psychopharmacology is like somebody said: "It is much more important to know what sort of patient has a disease, than to know what sort of disease a patient has." This practically means that the pharmacotherapist should get patient's developmental and social history to make reasonable hypotheses about the psychological origins of the patient's treatment resistance. The prescriber should assess the patient's attitudes about medications (fears of dependency, worries about being "turned into a zombie," and so on). This not only helps assess potential sources of resistance, but it also let the patient know the prescriber is interested in him as a person, which may enhance the therapeutic alliance.
3. *Attend to the patient's ambivalence about the loss of symptoms*: It is important to identify potential sources of ambivalence about symptoms, such as secondary gains, and communicative or defensive value of symptoms. It may be helpful at the point of intake to ask the patient what he would stand to lose if treatment was successful (but this question should not be reflection of doctor's frustration, otherwise may produce a negative response).
4. *Address negative transferences and resistance to medications*: Negative transferences must be identified and worked through. Once potential sources of resistance to the medication or the doctor are understood, these must be addressed. If they are clear at the outset, they must be addressed preemptively. In this way, an alliance is made with the patient before massive resistance is sparked. Empathic interpretation of nocebo responses can resolve adverse effects (Mintz 2002).
5. *Be aware of countertherapeutic uses of medications (resistance from medications)*: Countertherapeutic uses of medications should also be interpreted. A prescriber sometimes might be tolerable to the patient's irrational use of medications, understanding that the patient is working through an issue that interferes with a healthier use of those medications. In that way, psychopharmacotherapist can expect a condition of continued pharmacological treatment instead of countertherapeutic uses.
6. *Identify and contain countertransference in prescribing*: When patients struggle with over-whelming dysphoric affects, they often evoke corresponding effects in their prescribers. A medication regimen often reflects counter-transferential experience of the psychopharmaco-therapist and such a regimen is unlikely to be effective. Sometimes is perhaps aimed at treating the doctor's anxiety rather than the patient's; the patient is not the only source of treatment resistance. A psychodynamic psychopharmacotherapist must recognize his countertransferential problems in order to manage irrational prescribing.

Prescribing medication, psychopharmacotherapist always has to obtain the so called „psychotherapeutic frame"(Bull 1985), containing psychotherapy within a room, within certain times and under certain condition, i.e. psychotherapeutic setting. The objective is to provide a frame for therapy within which the therapist can look at what his patient is doing. This frame comprises all the phenomena included in the relationship between the therapist and the patient, and just like an artist who chooses the frame to hold his picture together, to contain its boundaries and to fix attention on that which is contained within his painting, the therapist must consider the existence of the psychotherapeutic frame. Psychoanalytically speaking, on the part of the patient, frame comes to represent the most primitive part of the personality – it is the fusion of the ego-body-world on whose immobility depends the existence. Especially psychotic patients bring, in the most obvious way, their own frame into their therapy, and the therapist is the one who must enable to develop it into a stabilizing foundation on which the organization of the personality can take place. The psychotherapeutic frame is a permanent presence for the patient, and is comparable with the Winnicott's concept of "holding" (Winnicott 1976).

CONCLUSION

Psychiatrists who operate from either a dogmatic psychotherapeutic paradigm or a psychopharmaco-logical paradigm are not having access to the patient as a whole. Psychodynamic psychopharmacotherapy combines rational prescribing with tools to identify irrational interferences with effective use of medications, i.e. to resolve the problems of the pharmacological-treatment resistance.

There are many sources of pharmacological-treatment resistance. A treatment resistance arises from the level of meaning, i.e. psychodynamic, interpersonal and psychosocial factors. It's inevitable to apply psychodynamic contributions that enhance the integration of meaning and biology. It is the capacity to integrate and understand complex situations that lends its particular power to discipline and skills for working with the most troubled patients.

In conclusion, it's useful to note Jakovljevic's sentences: "…We should remember that different psychiatry is possible… Transdisciplinary holistic integrative psychiatry provides a new conceptual framework for describing mental health as well as for defining and treating mental disorders in a more complementary way addressing biological, psycho-logical, socio-cultural, energy-informational, and possibly spiritual causes or meaning of psychiatric symptoms "(Jakovljevic 2008).

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