Pharmacotherapy as an Intervention during the Stages of Psychotherapy

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Although usually considered a medical intervention, pharmacotherapy may also function as a psychotherapeutic intervention. The prescription of medications may aid in the establishment of the working alliance, further the understanding of key dynamic issues involving resistance, transference, and countertransference, and assist in the initiation of change and in the process of working through.

Psychiatrists appear to be combining medications and psychotherapy as a regular part of their clinical practice.[1] A survey of members of the American Psychoanalytic Association suggested that 60% of analysts use medications with some of their patients.[2] An unpublished survey of psychiatrists in the state of Washington suggested that 40% of their patients are treated with the combined approach.[3] Much research effort is being directed toward evaluating the effectiveness of combined therapy in depression,[4] certain phobias,[5] and schizophrenia.[6] The Group for Advancement of Psychiatry has attempted to define some of the current problems with combined therapy.[7] A group of psychoanalysts delineated some principles concerning combined therapy.[8] The purpose of this article is to outline a conceptual framework for the use of medications within the context of the psychotherapeutic interaction.

Some Basic Elements of the Psychotherapeutic Process

In addition to resistance, transference, and countertransference, medications may affect other aspects of the therapeutic process. The timing of the offer of a prescription relative to the stage of therapy can also assist in accomplishing the goals of each stage. For example, medications can help to involve people into the therapeutic process and to strengthen the therapeutic alliance. Pharmacotherapy can reduce symptom-engendered interference with effective psychotherapeutic communication. Proper timing and dosage of medication can help to initiate change and to accelerate the working-through process. These objectives may be accomplished through placebo

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effects as well as the pharmacological effects of psychiatric medications. (Except where noted otherwise, all of the following examples come from my own cases.)

Engagement

Much of the study of combined therapy has focused upon the initial stage of treatment. Weissman et al.[4] have examined the effects of medications offered at the beginning of the psychotherapy of depressed patients. Klein et al.[5] have investigated the need for psychotherapy in certain phobics treated with antidepressants. Hogarty et al.[6] have studied the value of sociotherapy and medications in the treatment of schizophrenia. Since these researchers analyzed the effects of two distinct modes of treatment, little attention was paid to the study of the pragmatics of medication administration within the context of a psychotherapeutic relationship. Lesse[9] has addressed the practical details of combined therapy with particular attention to tranquilizers and antidepressants prescribed during the first stage of therapy.

The goals of combined therapy during the engagement stage are to reduce initial symptoms of anxiety and/or depression and to establish a therapeutic alliance. The latter goal and perhaps the former may be achieved through placebo effects as well as through the specific physiological activity of the medications.

The methods by which these goals are achieved include explaining the specific effects, limitations, and side effects of the medication in the context of a positive expectancy.[9] The patient should be encouraged to be an active collaborator who is as well versed in this practical information as the therapist, and who is therefore able to report specific drug-induced changes.

A positive response to medications may have a number of different effects on the therapeutic relationship during the engagement stage. Treatment with 8mg. of perphenazine,[10] enabled a borderline patient with a mild thought disorder to refrain from talking about her nightmares, fears of the dark, and thought racing and to focus upon the problems of the marriage. Another more psychotic patient successfully treated with neuroleptics returned to therapy saying: "You helped me in one way and now I am back to see if you can help me in other ways." Both patients were quickly engaged in a therapeutic alliance because of the pharmacological reduction of their psychotic symptoms. Placebo effects may also engage patients.

For example, a 37-year-old man sought lithium carbonate because of mood swings and because his manic father was successfully treated with it. The patient was also deeply paranoid and isolated. The lithium was only partially successful in controlling his mood swings leading him to discontinue it. However, discussion of its administration provided a matrix upon which a therapeutic alliance was slowly built over 18 months which provided a foundation from which much of his paranoia could be reduced.

Active pharmacological effects may create many problems for the therapeutic relationship during the first stage. Excessive doses of antidepressants in depressed manics may lead to mania. Excessive doses of neuroleptics may lead to lethargy and depression. Side effects like seizures with tricyclics may destroy a therapeutic alliance. Paranoid patients may interpret drug side effects as therapist malevolence. Patients may too quickly return to previous social and work patterns, which may lead to more difficulties. Also, family members may seize upon the positive change as a reason to prematurely terminate treatment.[9] Ostow[11] has suggested that pharmacotherapy may result in symptom substitution but this notion must be evaluated in the context of research in behavior therapy.[12]

Pharmacotherapy may be overused as a placebo engagement technique. If medications are used to seduce patients into therapy, physicians may face additional requests beyond accepted treatment methods.

The Therapeutic Alliance

Some patients require a strong therapeutic alliance before they will accept medications.[13] Patients who are mistrustful of physicians, wary of medications or doubtful about their efficacy will need to feel confidence in the psychiatrist's ability and concern in order to accept the prescription.

The manner in which a medication is prescribed may affect the type of alliance developed between patient and physician. Dickes[14] has differentiated the therapeutic alliance from the working alliance. He defined the factors of the therapeutic alliance that enter into the rapport including the patient's motivation for treatment, positive transference, and the rational relationship. The working alliance refers more specifically to the joining of the two observing egos to investigate the problems of the patient's experiencing ego. The working alliance is not necessarily activated in the presence of a good therapeutic alliance.

The manner in which the medication is prescribed can influence the development of a good working alliance. If the physician makes the patient a collaborator in the medication management, by informing him/her about side effects, mechanisms of actions, and targets for change and discusses these factors in detail, the patient's observing ego is more likely to be activated for the analysis of medication effects and for subsequent psychotherapeutic investigation. Without this attempt to increase self-awareness through collaborative effort, patients will tend to respond to effective drug treatment with a good therapeutic alliance but without a strong working alliance. In this way the prescription of medications begins to resemble the offer of interpretations which the patient must choose to "metabolize" in his/her own way.

Resistance

Just as patients may fail to follow expected psychotherapeutic procedures, they may resist the acceptance of medications. In medical practice the common physician response is to urge the patient to take the medication by extolling its potential benefits and by invoking the physician's authority and knowledge. When viewed from a psychotherapeutic perspective, the refusal to take medications may be linked to any one of the many common reasons patients refuse to follow expected psychotherapy behavior. For example, a 48-year-old, passive, dependent engineer refused to take lithium for an apparent manic-depressive variant. Analysis of this resistance suggested that he feared losing his disability compensation if he returned to work and failed again.

Transference

Medications may affect the patients' thoughts and feelings about the therapist in a number of ways probably similar to the ways in which they would react without medications but perhaps exaggerated. Lesse[9] described an excessive positive transference which renders the patient inert and compliant. While it may be associated with excessive medications, it may also be supported by a therapist who fails to interpret overdependency based upon magical expectations of the therapist's ability. The therapist's own emotional needs to see effective medication as his own power, will prevent accurate detection of drug-related transference.

Interpersonal responses to pharmacotherapy may reflect characteristic interaction patterns. Consider the following three examples:

Case Vignettes 1–3

1. A 42-year-old woman in combined therapy for three years called the clinic to get a medication refill. She became extremely depressed when I did not return her call for two days. When we finally made contact she expressed great anger at the receptionist. As we examined this intense reaction, she revealed that she was afraid that I would abandon her as a patient and that she reacted similarly whenever her husband went on a business trip.

2. A 47-year-old woman in combined therapy for five months requested medication for sleep. When questioned she refused to describe her symptoms of insomnia but became more insistent that I give her a prescription. The demands escalated and we reached a stalemate. Slowly she revealed that she had sexual fantasies about me and that she needed the medication to overcome these thoughts.

3. A 48-year-old man had been in psychotherapy for almost half his life. He described numerous therapeutic relationships in which he had first become deeply involved and then gradually became angry and disappointed, finally leaving them,

hoping to find a new and better therapist. He readily engaged with me. I tried series of antidepressants with him each of which worked well for a week and then h no reported effect. He became angry with me, criticized me for my incompetence a left to find help somewhere else, repeating the old pattern.

Countertransference

The evolution of the variety of definitions of countertransference h been reviewed by Langs.[15] In this article countertransference will refer those therapist reactions which impede the progress of therapy, i.e., counte resistance.

Mandell[16] suggested that an effective medication may result in narcissi tic injury to the therapist because it reduces the need for his/her psychothe apeutic efforts. A significant portion of psychiatrists appear to believe th medications allow patients to avoid the "real work" of therapy by preventi intrapsychic personality change. For example, a 37-year-old housewife w self-referred because she had become depressed for the tenth time in t years. She had been in psychotherapy for most of that time during whi she had made three suicide attempts. Her previous therapist had started h on an antidepressant which cleared her depression. After six weeks, s reported that he told her, "If you continue to feel so good we'll never find t cause of your problems," and discontinued the medication. She relaps and sought additional treatment with me six months later. Three yea after restarting medication she had changed significantly with infreque visits to regulate her dosage. Perhaps the medication permitted her to p into practice what she had previously learned in psychotherapy.

Medications may be given, however, too easily. Langs[17] described a ca in which the therapist became uncomfortable with the patient and appear to prescribe axiolytics because of his own discomfort, producing negati effects in the patient. The following case illustrates the necessity to be ab to stop medications in the service of the psychotherapeutic relationship.

Case Vignette 4

A 28-year-old prostitute and drug abuser with a diagnosis of minimal bra dysfunction of adulthood was started on dexedrine and desipramine as she start back to school and had stopped taking her sedative-narcotics. I planned to switch h to the desipramine alone. Unfortunately, her interpersonal difficulties caused her be expelled from school, whereupon she began to overdose on dexedrine. I becan paralyzed by my overly acute sensitivity to the potential narcissistic injury withholding further medications. We reached a stalemate which she "cured" shifting the prescription responsibility to the physician who had prescribed h previous drugs of abuse. Subsequently she asked me to have sex with her. M refusal destroyed the weak therapeutic alliance and eventually led to her suicide wi stored-up desipramine.

Stimulants have been reported to be of benefit to adults with minimum brain dysfunction[18,19] and some work has been done on the psychotherapy of such patients.[20] I believe I offered her the medications too early; we should have worked on her interpersonal deficits. In two similar cases involving colleagues of mine, patients requested that they be trusted to handle their medications, as had mine. Wanting to trust them, these colleagues had given their patients medications which were also used in successful suicides. Because of the potential danger inherent in psychoactive drugs, physician-therapists must be able to select those patients who are able to use medications safely and those who are not.

Initiation of Change

Pharmacotherapy may be used to initiate change in patients who have a reasonable understanding of the psychodynamic, interpersonal and/or situational variables which contribute to psychological difficulties but who are unable to act. Mandell[16] described a young woman who became increasingly apathetic in response to apparently accurate transference interpretations. The patient was given an MAO inhibitor which helped to increase her activity level and assertiveness thereby establishing a positive feedback loop which helped to change her derogatory self-concept. Marks describes research which suggests that diazapam could be helpful in exposing phobics to the feared circumstance.[21]

Conversely, psychotherapy may be a useful adjunct to the pharmacotherapy of panic attacks. While the attacks themselves may be successfully treated with imipramine, some patients experience continuing anticipatory anxiety. They may need to be encouraged to face the situation with psychotherapeutic support. For still others, amelioration of the panic attacks may have a significant impact on their social systems which may prevent change from taking place and therefore require more extensive psychotherapeutic efforts.[22]

Working Through; Maintenance and Generalization of Change

Once new patterns of thought and action have been initiated they often must be practiced in order to become a regular part of the patient's life. Medications may also assist in this stage of therapy. For example, a 32-year-old housewife, depressed for the last three years of her marriage, finally obtained a divorce and began to build an independent life of her own. The insights of her two years of therapy seemed to assist her. However, she gradually became depressed again and attempted suicide. The addition of a tricyclic antidepressant for clear vegetative signs helped her to continue on the path she had begun.

The placebo effect of medications may also be incorporated in the

working-through process. A 37-year-old woman was given lithium for manic-depressive disorder diagnosed by history; however, she responded be to low-dose neuroleptics. She was a passive, compliant person who grac ually became more assertive and independent. She periodically asked if sh could stop the lithium; I turned the question back to her. Gradually sh decided herself to reduce and stop the medication, a decision which correlate with her increasing ability to make her own decisions.

CONCLUSION

A number of guidelines may be induced from this presentation.

1. Pharmacotherapy can aid in the process of psychotherapy, both through the specific biological activity of the medication and through it placebo effects.

a. The specific biological activity can aid in the establishment of a working alliance by demonstrating to the patient the therapeutic competence of the physician. Through the relief of symptoms, pharmacotherapy may also remove blocks to effective therapeutic communication by freeing patients to examine underlying psychological conflicts. Medications may aid in the initiation of change. During the process of working through, medications may assist in the implementation of understanding by removing symptomatic blocks to integrating this understanding to daily life.

b. Shapiro and Morris[23] (p. 371) defined placebo effects as: "Any therapy or component of therapy that is deliberately used for its nonspecific psychological, psychophysiological effect, or that is used for its presumed effect but is without specific activity for the condition being treated."

While medications are ideally given for specific diagnostic indications, they are not always effective because the diagnostic indications are not completely clear or accurate. In these instances where the specific pharmacological activity does not result in the desired symptomatic relief, the placebo effect of the medication may be utilized to further the therapeutic process. For example, negotiations around medication management may provide a matrix within which a therapeutic alliance is built. Reduction of ineffective medication may aid in the maintenance and generalization of change by providing another indication that the patient is improving.

2. Pharmacotherapy may augment transference reactions similar to those which take place without medications. The request for medications by the patient may reveal underlying erotic or dependent transference relationships. Negotiations around medications may reveal characterological traits which are present in other interpersonal transactions.

3. Physicians' attitudes toward pharmacotherapy may hinder therapeutic movement. Those psychotherapists who do not believe that psychological change can or should be aided by pharmacological means will deny

some of their patients an effective therapeutic modality. Medications are, however, powerful psychological interventions and must not be managed in a casual manner. Because of their potentially great impact on the life of the patient and the meaning which medications carry about the therapist and the therapeutic relationship, medications may be turned against therapeutic change. They can offer an easy means to suicide.

The need for the further development of guidelines such as these is becoming increasingly apparent as psychiatrists recognize the need to combine as many effective approaches to therapeutic change as are available.

SUMMARY

Pharmacotherapy may 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. Medications, like verbal interventions, may help or hinder engagement, resistance, transference, countertransference, and working through. One of the major challenges to current clinical psychiatry is the development of firm guidelines for combined therapy.

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