CHAPTER 2

Medications During Psychotherapy: Case Studies of the Reciprocal Relationship Between Psychotherapy Process and Medication Use

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Psychiatrists interested in combining pharmacotherapy and psychotherapy have predominantly relied on psychodynamic concepts. The reason for this choice of therapy schools lies in the strong historical link between psychoanalysis and psychiatry. There is much irony in this amalgam, not the least of which is the strong antibiological bias within psychoanalysis both historically and today despite the fact that many psychoanalysts are trained as physicians first. The decline in numbers of psychoanalytic patients and the increased evidence for medication efficacy have fostered the clinical and theoretical papers on combined treatment.

As this uneasy rapproachment between the biological and psychoanalytical was taking place within psychiatry, other schools of psychotherapy were gaining prominence (e.g., cognitive-behavioral and existential-humanistic). Although psychoanalytic thought remains the major influence in psychiatric training programs, practicing psychiatrists seem to describe themselves in more eclectic terms. This self-description is a response to the varying needs of their patients and the obvious utility of contributions from other schools of therapy. Psychiatrists are now confronted by two major conceptual challenges for their clinical work: 1) how to integrate the schools of psychotherapy and 2) how to integrate pharmacotherapy with an integrated conception of psychotherapy. This chapter is part of a continuing effort to solve these problems.

Many variables influence the decision to introduce medications into psychotherapy. Most critical are the therapist's own biases for

and against such treatment and the diagnostic indications discussed in Section II in this volume on specific diagnoses. Other major influences include form of therapy (individual, group, family, marital), school of therapy (psychodynamic, cognitive, behavioral, existential), frequency and length of sessions, outcome criteria and goals (minimize cost, symptom reduction, prevention of relapse, interpersonal change), type of drug, route of administration, and treatment setting (1). Also critical is whether or not treatment is to be split between a pharmacotherapist and a psychotherapist, as discussed by Chiles et al. (Chapter 5, this volume).

In this chapter, these complex variables are subordinated to the general task of predicting and hopefully controlling the influence of pharmacotherapy on the psychotherapeutic process. From this perspective, psychotherapy is perceived to be the primary treatment mode, and pharmacotherapy is perceived to be a facilitator. Ward (Chapter 4, this volume) reverses these priorities: psychotherapeutic concepts are utilized to maximize pharmacotherapeutic response.

In previous psychodynamic attempts to describe the interaction between medication and psychotherapy, great emphasis has been placed on the effect of medications on the therapeutic alliance, on the effect of medications on the manner in which defenses may be altered, and on the varieties of meaning that medications may assume for patients receiving them (2–6). The position taken in this chapter is a refinement of previous attempts to lift the psychotherapeutic perspective on combined therapy out of the psychodynamic confines and place it in a broader context (7,8). The current chapter encompasses a two-step integrative process: the first step is to provide a model for integrative psychotherapy; the second is to integrate pharmacotherapy with an integrated concept of psychotherapy.

The following section contains a brief overview of the movement to integrate the psychotherapies, emphasizing the need to find common factors while recognizing the individual contributions of each school. Next, a model incorporating these objectives is described, one that appears particularly useful for studying the interaction between medication use and individual psychotherapy. Table 2-1 summarizes the stages of psychotherapy, with medication examples illustrating the components of each stage. The following sections are composed of 23 case examples of the interaction between medication use and psychotherapy process.

A Model for Integrative Individual Psychotherapy

Over the past decade the movement toward integrating the psychotherapies has grown in influence (9). There have been too many

Table 2-1. The stages of individual psychotherapy: a medication emphasis

Stage	Engagement	Pattern search	Change	Termina
Goals	Trust Credibility Self-observer alliance	To define problem patterns that, if changed, would lead to a desirable outcome	1. Relinquish old pattern(s) 2. Initiate new pattern(s) 3. Practice new pattern(s)	To separ
Techniques	Convey empathic understanding Effective suggestions Effective medications	Questionnaires Homework Idiosyncratic meanings Ascribed to medication	Interpretation Reframing Behavioral suggestion Medication-induced change	Mutually Patient i Therapis Medicati
Content	Medication responsive Diagnosis	Does response to medication reflect a problem pattern?	Medication effects, or insight around medication use accelerates change	Medicati terminat
Resistance	Are excessive side effects resistance to treatment?	Does pattern of non-adherence to medication regimen reflect a problem pattern?	Do new side effects suggest resistance to change?	Sympto not nece for medi
Transference	Physician seen as malevolent or all powerful	Is key interpersonal pattern reflected in meaning of medication?	Unresolved distortions may be signaled by a new medication issue inhibiting change	Desire fo medicati to hold t
Countertransference	Physician failure to prescribe appropriately	Medication prescription reflects distorted response to patient	Sudden change in regimen reflects an attempt to undermine change	New me desire to

schools of therapy, each attacked from all sides in a kind of sibling rivalry. Third-party payers and psychotherapists themselves have been asking "what is psychotherapy." Can it be well defined?

One clear direction is embodied in the search for common factors. What is it that defines the psychotherapies as psychotherapy? Psychotherapy is a series of events through time and may therefore be considered a process. This process has been divided into stages by many previous writers. Stages may provide a solid conceptual foundation on which to rest the contributions of the various schools of psychotherapy. These stages may be called: engagement, pattern search, change, and termination (10).

This scheme, however, is insufficient because each of the many different schools has something unique to offer as well. Therefore, a sensible approach to integration is to define what is basic to psychotherapy and then incorporate the unique contributions of the different schools into the common factors. For example, psychoanalysis has contributed valuable information about the psychotherapeutic relationship, the self-observer alliance, transference, and countertransference. Cognitive therapy has called attention to the ever-present "automatic thoughts" and their related cognitive schemata by offering methods for defining and changing them through diaries, experiment, and self-talk. Behavior therapy has offered reinforcement of both the classical and operant types. Existential therapies have contributed the concepts of death anxiety and fears of responsibility as well as the usefulness of I-Thou confrontations. In this way, psychopharmacotherapy can be seen as yet another school of psychotherapy having contributed the placebo response, biological theories of mental illness, and active medications.

The Structure of Each Stage

Each stage may be seen to be composed of six elements: goals, techniques, content, resistance, transference, and countertransference.

Goals

Goals define the boundaries of each stage. Once a goal is accomplished, the stage associated with it has been traversed. However, patient-therapist pairs must often retrace their steps to firm up their engagement or to clarify and define patterns. The goals of engagement include the patient's development of trust and confidence in the therapist as well as a willingness to be influenced. The pattern search goal is the explication of a problem pattern or set of problem patterns that, if changed, will bring about a satisfactory psychological shift.

One pattern may not be sufficient: multiple patterns may be examined and discarded before some elements that can lead to an adequate resolution are defined. The goals of change are tied to their subgoals: the relinquishing of the old pattern, the initiating of the new, followed by practice and maintenance. The goals of termination include separating early enough to maintain goals already achieved while not extending the relationship unnecessarily.

Techniques

A wide variety of techniques may be used to accomplish the goals of each stage. Some techniques are most useful in the engagement stage (e.g., empathic reflections) and others are better suited for change (e.g., behavioral rehearsal), although many techniques may be useful in all stages. The critical question is what techniques may be most useful for accomplishing the goals of each stage for which patients. Medications may play a part in the accomplishment of the goals of each of the stages.

Content

The content of therapy is the least predictable aspect of the psychotherapeutic process. The wide variety of personality and psychopathology theories attests to the uncertainty therapists have in knowing what to talk about. There appear to be some general themes within each stage. Engagement is concerned with trust and competence. Pattern search is most often associated with problems in daily living surrounding interpersonal relationships. Change involves trying out new thoughts and behaviors followed by attempts to repeat and maintain successful ones. Termination is concerned with trying out new actions alone and having to say good-bye.

Other Elements

Each stage may also have characteristic distortions manifesting as resistance, transference, and/or countertransference.

Table 2-1 contains elaborations on this model, with particular attention to the manner in which medication use during psychotherapy can highlight its various aspects. Most of the descriptions mentioned in the table are illustrated in the following case examples.

ENGAGEMENT

During the controlled studies of combined therapy, researchers generally administer drug or placebo at the outset of therapy. Therefore, their findings have little to offer in describing what goes on if medica-

tion has not been introduced at the beginning of therapy. In clinical practice, psychiatrists weigh several variables before deciding on either medications or psychotherapy or a combination of the two. For some diagnostic indications (e.g., depression), some psychiatrists advocate a two-stage model by which the patient is offered a medication trial, which may obviate the need for psychotherapy if successful (11). Increased energy and improved mood may propel the patient out of the negative spiral of hopelessness and despair, replacing it with a more positively reinforcing loop. If the medication trial is only partially successful, then the patient may be invited to embark on a course of psychotherapy, assuming another antidepressant is not to be considered. This simplistic approach becomes much more complicated in actual practice. Variables of critical importance include the patient's and the psychiatrist's predisposition toward either psychotherapy or pharmacotherapy and the specific diagnosis.

The psychiatrist may be predisposed to giving medications with several rationales, including the wish to give the patient quick, immediate, and inexpensive symptom relief. With this thinking, the two-stage model described above may become a prolonged one-stage model since there is reasonably good evidence that people who are depressed may sometimes need 8 to 9 weeks of a clinical trial with an antidepressant at a reasonable blood level before symptom relief can be achieved. On the other hand, the psychiatrist may offer only psychotherapy from the beginning and wait to see if this approach can bring some relief of symptoms. The more one uses this second approach, the more one finds that some patients, however difficult to characterize, will respond positively to a good treatment alliance after a few weeks of therapy and therefore may not appear to need medication. The therapist's rationale may include statements like "I will give the patient more control of his symptoms and more durability over time for symptom relief." However, psychotherapeutically oriented psychiatrists may need to be careful about overextending this approach since precedent has now been set for legal action against clinicians who withhold antidepressants for treatment-responsive depressions, as shown by the Oscheroff case (12).

Some patients want only medications, and others want only psychotherapy. Those who ask for medications only may simply want immediate relief and not care what the means is. On the other hand, those who want psychotherapy only may reject medications out of fear of some external control, preferring instead a sense of personal control. Although each of these positions may be considered resistance to oppositely oriented psychiatrists, they are more specifically resistances to the bias of the psychiatrist.

Diagnosis is a critical variable in determining predisposition toward offering medication or psychotherapy. These issues are discussed in detail in Section II in this volume on specific diagnoses. Diagnostic information is placed against the psychiatrist's experience and knowledge base to formulate a predisposition toward or against single treatment or combined treatment.

When medications are to be given during a psychotherapeutic relationship, there are two time frames in which they may be prescribed during the engagement stage: 1) at the onset, pills may be given during the first session or early on in therapy, or 2) delayed, engagement may be necessary before the patient is willing to accept medication.

Medications as Engagement Techniques

The following case illustrates the notion that, if medications are effective, the patient may then ask for psychotherapeutic help.

Case 1. A 38-year-old woman presented with racing thoughts, auditory hallucinations, and delusions of persecution. A trial of perphenazine successfully quieted her anxieties and put distance between herself and her delusions. She viewed my handling of her psychosis to be compassionate as well. For administrative reasons, I referred her to another psychiatrist with whom she reached a statemated, eroticized relationship from which the therapist uncomfortably fled by referring the patient to his wife's therapy group. Sensing the manipulation, the patient called me and requested reacceptance into treatment by stating "You helped me once and now I'd like you to help me again." Although she resumed the relationship with intense erotic fantasies, she persevered with the knowledge that she had been helped once before by this same person. Medication management had instilled hope for improvement, one of the common underlying factors of most psychotherapies (13).

Ineffective Medications as Engagement

The following case illustrates how medications, although ineffective, became a central focus for discussion, helped to develop a self-observer alliance between patient and psychiatrist, and led into psychotherapy.

Case 2. A 36-year-old single man sought help for his self-diagnosed manic-depressive illness. He had been treated with amitriptyline with great success, but he experienced times of hyperexcitability, irritability, and rages while taking that medication. He had decided that

lithium was the best treatment for him. As he described his symptoms and his life-style, it quickly became clear that he was terribly isolated and very paranoid; these characteristics seemed independent of his apparent mood swings. Police were always after him, the landlord was constantly plotting to evict him, and store clerks consistently mistreated him. For 18 months lithium therapy remained the focus of treatment, with occasional forays into investigations of his paranoid thinking. His descriptions of the current economic system and his opinions on politics and history dominated our interactions. People in the next room could hear him raging. Gradually we discovered that lithium offered very little help for him despite his history of mood swings and his father's positive reaction to lithium treatment for a more classic manic-depressive illness. By that time he had begun to allow me to express my opinions about him, and he began to confront the boredom and loneliness of his life. Medication management had provided a vehicle through which he could begin to trust me enough to listen to me and to express the feelings underlying his paranoid and isolated existence.

Side Effects May Prevent Engagement

Medications may not only be ineffective; side effects may be so bothersome that psychotherapeutic possibilities are cut off. This idea is illustrated in the following case.

Case 3. A 30-year-old woman with advanced Hodgkin's disease and a demanding, highly critical, antagonistic personality style was begun on doxepin for depression before she had been engaged in a psychotherapeutic relationship. She gained little effect at 200 mg; with some encouragement by her, the psychiatrist raised it to 300 mg. She suffered a grand mal seizure, which offered a clear-cut reason to drop yet another in a long line of caregivers.

In fact, this patient had a history of repeated initial willingness to be treated in a variety of ways by a variety of people and had, after a short period of time, always found something wrong with whoever decided to try to help her. This appeared to be use of medications as a resistance to engagement.

Engagement May Be Necessary Before Medication Acceptance

Engagement may be necessary before medications will be accepted by the patient. This principle may be particularly true for paranoid patients. The following case illustrates difficulty in engagement to which the premature offer of medication may have contributed.

Case 4. A 26-year-old paranoid graduate student, only 2 years in the United States after living all her life in Hong Kong, sought psychiatric help because of anxiety and isolation. When the therapist suggested a neuroleptic for her obvious psychotic thinking, the patient balked and came irregularly to appointments. She indirectly referred to fears of trusting the therapist and finally was lost to follow-up (8).

In the section on change, Case 18 illustrates the notion that a patient may need to identify an interpersonal pattern before being able to accept a denied DSM-III-R (14) Axis I diagnosis.

Transference in Engagement Stage

Patients and therapists respond to each other through medications in a variety of distorted ways. The following is an example of a grandiose transference keyed by the successful use of medications.

Case 5. A 28-year-old woman presented with daily migraine headaches and episodic anxiety. She had a history of physician-prescribed codeine abuse. Because her anxiety was often incapacitating, she requested diazepam. She was also clearly testing my ability to trust her with this request and thereby attempting to gauge her willingness to trust me. Her relationships with most men were characterized by finding herself always depreciated and used by them as she had been depreciated by her father. When, early in treatment, I gave her a small number of 1-mg tablets of diazepam, she idealized me as a perfect therapist for her. This response required careful monitoring during the remainder of a successful psychotherapy.

Countertransference in Engagement

The following case illustrates the manner in which therapist omissions around medications may reflect an unspoken negative bias against a patient.

Case 6. During the engagement stage with a particularly troublesome 25-year-old unmarried man, a psychiatrist became frustrated with the patient's demands for medication and excessive reports of shifting side effects that seemed to accompany any medication use. In desperation, she tried the patient on a monoamine oxidase inhibitor and left town for 2 weeks without clarifying the foods to be avoided and the person designated to be her back up. The patient called to inquire about side effects and found no one to answer his questions. These omissions appeared to be the product of unconscious anger at a noncooperative patient. The patient quit therapy soon thereafter.

Transference/Countertransference Spirals

Transference-countertransference reactions may spiral together to reach a stalemate that, in hindsight, began early in therapy. Medications may provide a matrix through which stalemate spirals are developed.

Case 7. A 28-year-old borderline woman, who presented herself for treatment in a very helpless, lost, and needy way, pleaded for antidepressants and antianxiety medications during the first interview. She had a history of suicide attempts, one almost fatal. There was no indication for the antianxiety medication, yet I responded with the prescription-rescue response she seemed to wish to elicit (15). She used her helplessness in many other circumstances (e.g., her chair was too uncomfortable, would I please find another for her?) to weave me into a web so tight that only a moderate overdose attempt followed by a hospitalization could break our relationship. I was relieved when she told me she had found a new therapist; the patient commented on my obvious relief as she said good-bye.

Pattern Search

The ideal of the pattern search is to define a pattern or set of patterns in terms that imply change. Patients' reactions to medications may be seen as projective tests reflecting through this medium a key pattern in need of change.

Boundary Violations

Psychiatrists often have to be guardians of the therapeutic frame by preventing disruptions from the outside from disturbing the relationship. The manner in which patients attempt to distort the therapeutic contract may serve to highlight a critical psychotherapeutic pattern (16). Patient requests around medications can be deceiving because these requests address the psychiatrist as physician, not as psychotherapist, and therefore may trigger nonpsychotherapeutic responses. As the following case illustrates, requests around medications can also be attempts by the patient to distort therapeutic boundaries.

Case 8. A 36-year-old sociologist sought therapy because of difficulties with his marriage. He had been in individual therapy twice before. The first time was for several years in another city; the second was more recently for marital problems. He terminated prematurely

from his second therapist in order for his wife to be able to be seen by this therapist.

The fact that the patient had essentially given up his therapist for his wife illustrated a central pattern to their relationship. Whatever she wanted and needed, he gave to her. If he brought home his favorite fresh-baked danish pastry, she could eat all of it with no protest from him. If she did not want to go on a vacation, he stayed home with her. His friends urged him to separate from her. He entered therapy for a third time stating that he wanted a divorce but could not do it.

After several months of gradually inching away from following her demands, he asked his psychiatrist to see her for recurrent depression. She was seeing another psychiatrist, but she knew that his therapist had a good reputation in affective disorders. The psychiatrist said "no." The patient persisted. "Perhaps you could just talk with her on the phone." "No." The patient had a great deal of trouble accepting this refusal. His psychiatrist pointed out to him that he was once again repeating a pattern of giving up something that was very important to him. "Remember the previous therapist. Remember the danish pastries." He was beginning to change his patterns with her; she knew it and was trying to subvert therapy to undo his moving away from her.

After several runs through the variations on the pattern, the patient was able to acknowledge his need to break it. The therapist was modeling that which the patient wanted to do by saying "no" to her requests. Several months later, acrimonious divorce proceedings began. Two years later, he was happily remarried and a father.

Perfectionism

In the following illustration, failure to respond to medication treatment highlighted the patient's excessive perfectionism.

Case 9. A 40-year-old woman had seen multiple therapists for a narcissistic personality disorder. She continued to feel depressed and had premenstrual difficulties as well as panic attacks. She was started on low doses of imipramine, which helped reduce some of her symptoms. Nevertheless, the patient continued to complain about minor side effects and continuing symptoms of her depression. On analysis, it became clear that the patient was highly perfectionistic, demanding no flaws in her own performance and projecting this obligation on the medication that had been more beneficial than she could admit to herself.

Introjected Abuse

Often the solution to a problem is obvious but the patient does not take it. The reason for failing to do the obvious may reflect a basic intrapsychic/interpersonal pattern, as suggested by the following case in which the patient attempted to withstand medication "abuse" as she had withstood the sexual and verbal abuse of her childhood.

Case 10. A 38-year-old woman was being treated with 6 mg of clonazepam per day for a severe panic disorder. She had been in biweekly psychotherapy with a psychiatrist for approximately 18 months, having accomplished only moderate control over her panic attacks. As a child, she had been sexually abused by a series of stepfathers and severely physically abused by her mother. At 17 she married a man who was physically abusive.

They had two boys and were divorced. He continued to harass her through physical threats and financial blackmail. She was married to her fourth husband when therapy began. This husband was cold and distant until she initiated divorce proceedings. After much wrangling, he beat her and left. She realized the part she played in his anger and began to make significant strides toward independence. Her panic attacks became less severe, and she began serious plans for her own future. Over a weekend she misplaced her clonazepam and for 2 days had no medication. She did not call the psychiatrist until Monday, having been off the medication for about 60 hours. She had "a continuous panic attack for more than one day." Why had she not sought help earlier, knowing quite well that abrupt withdrawal from the benzodiazepine was likely to be painful? One obvious way to view her behavior was to suggest that she continued the pattern of abuse by doing it to herself. After being questioned about it, she stated, "I'm tough; I have to be tough. I tried to wait as long as I could." She had taken the same stance whenever her mother beat her, trying not to cry and not to beg for the beating to stop.

Defeating the Therapist

That medications can be involved directly in repeated interpersonal patterns is suggested by their part in the following pattern of repeated disappointments.

Case 11. A 48-year-old man had been in psychotherapy for almost half his life. He was referred by his psychologist to a psychiatrist for the possibility of medication management in addition to psychotherapy. The psychiatrist became intrigued with this case and, while offering a number of different medications to him, also delved into his psychotherapeutic history and difficulties. The patient was unsatisfied

with his psychologist and began psychotherapeutic work in addition to medications with the psychiatrist. The patient described numerous therapeutic relationships in which he had first become deeply involved, gradually became angry and disappointed, and finally left those relationships. He had just done that with the referring psychologist and had followed the same behavior pattern many times before. In pharmacotherapy, he went through a honeymoon period with each of the medications, then reported no effect. After a few months, he became angry and critical of the psychiatrist as a psychotherapist and left to find help elsewhere. He was repeating the same pattern.

Ambivalence

Difficulties in decision making characterize much psychotherapy since patients are often caught between two only partially attractive alternatives. To many patients, medications are attractive for their power to relieve symptoms but repugnant for their "addictive" and dependency-inducing qualities.

Case 12. A 35-year-old social worker had had a series of panic attacks in her early 20s. After 5 years of no panics, she had a major attack, 30 minutes after her marriage ceremony. She became moderately agoraphobic and relied on her husband not only to go places with her but also to be understanding of her during her panic attacks. She knew she wanted to get out of the marriage but was afraid she would not be able to find anyone else and was afraid to be alone with her panic attacks. She was moderately well treated by imipramine and alprazolam, with occasional breakthrough panics that convinced her that she needed to stay with him. After several therapeutic efforts to focus on her ambivalence about her marriage, she had a terrible week of panic attacks. Her psychiatrist confronted her with her options: raise your medication and allow yourself the freedom to leave him. She did not want to be dependent on the pills. On the other hand, if she was not dependent on pills, she needed to be dependent on her husband. She saw the choice: depend on her husband or depend on medications. Once again she voiced her opinion that if she were not with him, she would no longer need the medications. At last she agreed to raise the dosage of both medications and with that decision became increasingly more assertive with her husband.

Medications as Lethal Resistance

Medications may be used as a mechanism by which psychotherapeutic work is resisted. The following case illustrates the aggressive use of medications against psychotherapy.

Case 13. The patient was a 31-year-old woman who was hospitalized after developing a psychotic transference to her individual therapist. She reported a lengthy history of sexual abuse by her brothers, some cousins, and their various friends between the ages of 7 and 12. She was being followed initially for medication after her hospital stay, while simultaneously being in group psychotherapy and marital therapy. However, she regarded these brief meetings with her psychiatrist as her psychotherapy despite their brevity and lack of frequency. Following her discharge from the other modalities, she entered formal individual psychotherapy and pharmacotherapy with her psychiatrist. She frequently would hoard medications and would often threaten to take them if her psychiatrist was unable to see her immediately. Sometimes these demands came almost immediately after a session, before she had even left the hospital grounds following a meeting. Since the medications had proved ineffective, and she had repeatedly demonstrated her proclivity to hoard all prescribed medications (including nonpsychotropics) and use them abusively rather than as prescribed, they were discontinued. She was then more able to look at the forces operating on her to be self-destructive, and at the nature of the relationship between her and the psychiatrist.

Resistance as Key to Pattern Identification

On the other hand, resistance to taking medications may illustrate a key pattern that needs to be interpreted in order for the patient to accept medication.

Case 14. A 38-year-old divorced father of three had developed severe panic disorder followed by severe depression at age 32. He was treated with antidepressants and alprazolam after several months of no adequate diagnosis. "My psychiatrist saved my life." He entered psychotherapy with a rational emotive therapist practitioner and then, after much positive work, terminated. After a hiatus of 1 year, he began with a second nonmedical therapist, maintaining some contact with his psychiatrist on a monthly basis, and continued on antidepressants (alprazolam and prn flurazepam). He and his new therapist decided that they were not working well, and he was referred to me for psychotherapy. After resolving the question of whether I would also monitor medications (he decided to continue seeing his other psychiatrist on an occasional basis for medication follow-up), we proceeded to discuss his current social difficulties. Shortly before the second session, his 7-year-old daughter was found to have a very rare cancer for which no treatment was known. After months of scurrying around for answers and several blind alleys, he entered his daughter into a radiation treatment program. His life

stabilized with the new routine and the drop in uncertainty. However, his sleep became fitful and insufficient. He recognized a need for increasing his flurazepam dose but was resentful about having to do so. While he made it clear that taking the medication was very likely to help him, he was reluctant to do so. Why? Tearfully, he stated that his father (who was shot and killed by his schizophrenic mother when he was 30) had been an exemplary narcotics agent. To take these medications was to be disloyal to his father. I asked if I might speak to his father in him. He agreed. I told "his father" that his son needed these medications, perhaps in part for the effect his wife had on his son. "He needs to sleep. He is exhausted and frightened." The patient stated that his father would accept these reasons. He took the medication with apparently lowered guilt and better sleep. This intense loyalty was a clue to his rage at his father for passively allowing his mother to mistreat him during his childhood.

Erotic Transference

The common erotic transference may disguise itself within discussions of medications.

Case 15. A 47-year-old woman sought therapy for recurrent depressive episodes. Because of a suggestion of family history of affective disorder and the cyclic nature of her problem, I began her on a trial of lithium. She reported some relief at moderate doses but experienced side effects that greatly disrupted her life. She stopped taking the drug. As psychotherapy deepened into the pattern search, she asked for sleeping medications. She refused to elaborate on her symptoms of insomnia, but rather became more insistent that she receive sleeping medications. The demands escalated, and we approached a stalemate. Slowly she revealed that she was unable to go to sleep because she had sexual fantasies about me. She believed she needed the medication to help her overcome these thoughts. Therapy proceeded for 2 years, during which time a strong eroticized transference became a fixed part of our relationship. She would never permit discussion of her feelings toward me, but rather talked about other subjects or insisted, cajoled, and otherwise attempted to seduce me. Finally, after three unsuccessful terminations, she agreed that transfer to a woman therapist would hold more promise for her.

Countertransference During Pattern Search

Medication prescription may play a part in countertransference reactions during pattern search. Countertransference reactions may be either patient induced or therapist induced and usually have elements

of both. In therapist-induced countertransference, the patient reminds the therapist not only of someone from his past, but also of people involved in current situational and emotional difficulties. Patient-induced countertransference is the product of efforts by the patient to elicit certain responses from the therapist.

Case 16. A 28-year-old male therapist was seeing a 23-year-old woman who developed a strong sexualized attraction to him. The therapist could not consider himself attractive to women because sexuality disturbed him, so he offered an antianxiety medication to the patient. The patient was confused by this offer, was in no way aided by the medication, and questioned the therapist's ability to treat her. The patient was attempting to gain a sexual/caring response. The therapist's own problems led to an attempt to reduce his anxiety by relaxing her (16).

Change

The substages of change may be defined as giving up the old pattern, initiating the new pattern, and maintaining the new pattern with practice. In this section, the manner in which medications influenced these substages will be illustrated by several cases.

Giving Up the Old Pattern

In the following example, medications helped the patient define the pattern in need of change, and during a therapy hour she gave it up.

Case 17. A 55-year-old divorced mother of five adult children had been in psychotherapy for many years. She was referred from the internal medicine clinic because of her depression and hysterical personality. She was being treated with butalbital (Fiorinal) for intermittent headaches. Her personality style was one of intense desire to help others, but she was unable to accept warmth or nurturance or support for herself. I asked her to note the times she took the Fiorinal. It surprised her to realize that she often took it shortly after being criticized or frustrated by a colleague or employer. This realization helped her reduce the number of times she took the medication. During the pattern search, I was able to point out her difficulty in accepting help from other people. In fact, I became quite frustrated with this difficulty of hers. Toward the end of a particularly poignant session, she asked me to refill her Fiorinal prescription, a process that up to that point had been handled by her primary care internist. I reluctantly gave her the prescription. I also exasperatedly asked her why she was unable to accept emotional understanding and help

from anyone. She became furious with me and, in an effort to prove she could accept my personal help, decided not to fill the prescription; instead, she returned the form to me the following week, saying, "I wanted to prove to you that I could accept your help. I will try to accept your support and concern rather than pills." Six weeks later, as we discussed her relationship with her mother, she realized how much like her mother she was. Her mother, too, would plead for help from others, but would not take it. She described an incident in which she attempted to help her mother, but her mother would not accept it. She was able to contrast her own willingness to receive help with that of her mother, as dramatically illustrated by the medication use. In this way, she helped herself to differentiate her own patterns from those of her mother's.

In the following example, the patient recognized responsibility for a pattern of her interpersonal behavior that allowed her then to accept medication treatment. Up to that time she had not thought that she had anything wrong with her.

Case 18. A 45-year-old narcissistic woman was repeatedly perplexed by her pattern of repeated rejections from intimate relationships with men. During one dramatic session she was able to assimilate the real possibility that she actually engineered these rejections. The realization was so startling to her that she experienced a flu-like syndrome without fever as she allowed herself to see her influence over others. After disavowing the patterns, she attempted to eliminate her fear of intimacy. However, she experienced a long hypomanic episode followed by a severe depression. She was more able to admit that she had previous mood swings of this severity and that possibly she was manic-depressive. She had not been able to accept the diagnosis until she had accepted her now obvious interpersonal problems. She was then willing to take lithium.

Initiating Change

Medications may provide opportunities to initiate behavior change not only through symptom reduction but through their meaning to patients.

Case 19. A 22-year-old woman was referred for treatment by her psychiatrist because she was moving from her town to my town, where she intended to go to school. She was bulimic and had made a suicide attempt requiring hospitalization about 1 year before the

Maintenance of Change

In the following example, the patient was beginning to change but medication seemed to be hindering progress. The psychiatrist's response appeared to turn the side effects of the medications into another indication of positive change for her as part of practice and working through. This intervention was a "positive reframe."

Case 20. The 35-year-old woman with panic disorder and major depression described in case 12 was becoming more assertive with her husband. She noticed that if she did not assert herself, her panic attacks became worse. After several weeks of panic attacks, she would then become depressed. She discovered how her husband used subtle tactics to control her. Little looks, tones of voice, demands that she express gratitude to him for things he did even though she did not want him to do them, were among the ways she was controlled by him. She was starting to break free. He was also being a little kinder. Her panic attacks had come under good control with higher doses of imipramine and clonazepam. One day she came into a session very concerned about her excessive sleepiness at work. Sometimes she dozed off in the middle of an assignment at work. She reported having had a panic attack the morning of the appointment. "I am going downhill. I know it. I am going to need yet more medication and still I will have panic attacks. I'm scared."

Her sleepiness was primarily in the morning. The panic attack occurred right after she seemed to drift off to some "unreal" place. As she realized she was drifting off, she became frightened and had a brief panic.

"The sleepiness is a positive indication for you," said her psychiatrist, "because it suggests that your assertiveness is reducing your need for medication. You have not had a panic attack in several weeks, and this one appears related to the sedation caused by what is now too high a dose of medication. It is more evidence of progress." They reduced her morning dose. She continued to improve.

TERMINATION

Patients may force termination around medications; therapists may force termination, using medications to soften the blow; or termination may go along smoothly until medications represent a difficulty in separating. These points are illustrated in this section.

Patient-initiated Termination

In the following case, the patient prematurely terminated psychother-

transfer. Her father and several subsequent stepfathers were alcoholics as was her maternal grandmother. Her mother appeared to be an enabling co-dependent. Her mother also left her home with her two younger siblings while the mother went out on dates or left for weekend vacations, much as her mother's mother had done. The patient was under these circumstances forced to assume the role of primary caretaker for her siblings. At age 16 she discovered vomiting as a method of weight loss. Later it became her response to any general dysphoria. After she vomited she would feel relieved and proud that she had managed to survive this insult to her body.

She had a 6-year relationship with a man. He was kind and very devoted to her but not willing to give in to her unnecessary requests for aid and nurturing. She, however, found herself unable to show anger to him or even to recognize it in herself. She did not like to come to therapy partly because she did not want to become dependent on anyone. Therapy appeared to anger her for this reason, according to her previous psychiatrist, but rather than express it, she simply failed to come to treatment. She also failed to show up without calling me on several occasions, which I found at first frustrating. The more I was able to accept her pattern of failed appointments, the more reliable she became. We were able, however, to define anger as a kind of "phobia" to which she needed to be exposed. She found herself having trouble sleeping, low energy, increasing guilty ruminations, and other symptoms of depression. She began desipramine. After some problems with orthostatic hypotension, which resolved, she began to feel much better and was delighted with her improving status. In a subsequent couple's meeting, I helped her identify and express her anger at her male friend. Although they both squirmed, she felt that this event helped to break much of her early training against anger expression. We both felt that it helped to lift her depression. However, she began to be unable to lose weight. Although she was eating "correctly," exercising more, not binge eating, and in every other way doing very well, she was angry at me for having given her a medication that she thought did not give her control over her weight. She expressed this fury at me in measured, clear tones. She wanted guidance on how to stop the medication. She had lost trust in me. She also recognized that this was an excessive response, but she wanted that control over her body, which she felt the pills and I were taking from her. Perhaps I was experimenting with her.

This expression of anger was clear and articulate and preserved our relationship. It was an additional opportunity to begin her experience of anger expression. Unfortunately, she became depressed again and willingly restarted medications with good results.

apy because of her adverse response to medications during pattern search.

Case 21. A 21-year-old with panic disorder and agoraphobia selected phenelzine over imipramine and clonazepam because she preferred not to have dry mouth or be sedated and was willing to follow the monoamine oxidase inhibitor dietary restrictions. She responded positively with reduction in panics and phobic avoidance. Unfortunately, she became phobic not only of cheese-containing foods but of many other foods and would not eat even after the medications were stopped. She lost confidence in psychotherapy after 10 sessions, neglected to follow the therapist's request that she utilize a birth control method, and became pregnant. She then terminated the psychotherapy.

Pills to Reduce Pain of Termination

In the next example, the patient began to have reoccurrences of symptoms during the termination phase. This is not an uncommon reaction, but these recurrent symptoms are usually short lived. However, they are often an expression of fear of loss of the therapist and consequent fear of loss of therapeutic gains. If a therapist feels guilty about this recurrence of symptoms, then medication may be offered as a way to hold on to the patient, a way to subvert the termination process and continue contact through medications.

Case 22. A 30-year-old psychiatric resident had been seeing an intermittently psychotic 32-year-old man for 18 months one to two times per week. The therapist was heavily invested in the patient, who had made but modest gains. As the forced termination caused by his leaving the residency loomed only a few months away, the patient began to express his sadness and anger at the desertion. The therapist felt increasingly guilty and decided that he should consider starting the patient on lithium. Medications appeared to be the way to continue the symbolic contact after they separated and a low possibility chance at "cure."

Pills as Focus of Termination Transference

Finally, patients' responses to termination may manifest through reaction to medications, as illustrated in this example.

Case 23. A 43-year-old mother of three children, married since age 17, was referred to me by neurology for treatment of agoraphobia. Two months earlier, she had suffered an intracranial bleed, which had

left her left side paralyzed. She made a remarkable recovery after surgery, showing only minor changes in her neurologic examination. However, she reported to me symptoms of major depression with melancholic features. She had had numerous episodes of major depression in the past, but none were so severe as this. In addition to much crying, appetite changes, suicidal thoughts, early morning awakening, agitation, poor memory, and poor decision making, she also reported fear of dying and loss of control as well as "the feeling of death in my stomach." She was afraid of driving her car alone and reported that she felt dizzy and agitated in shopping malls. Her primary care physician had started her on amitriptyline 25 mg and alprazolam 0.5 mg tid. I raised her amitriptyline to 100 mg hs and declared her severely depressed. This labeling of the illness helped to reduce her depression about being depressed. One week later she had improved 75% according to her estimation. Further history suggested that her first panic attacks occurred around age 10 when she believed that something was wrong with her heart and that she might die. She reported being chronically plagued with thoughts of "what if . . ." leading to catastrophic possibilities.

Over the 4 years she repeatedly thanked me for helping her when no one else seemed to understand what was wrong. We examined her lack of assertiveness with her husband, her tendency to give to others without asking for anything in return, and how her failure to demand for herself had led to her not receiving much from her teenage daughter and her sons now in their 20s. We explored the reality of her "what if . . ." fears. I encouraged behavioral exposure to driving and to shopping. After 3 years we reduced the frequency of therapy to once every 3 months. When she came to one meeting, she told me of yet another problem that she had encountered that was somewhat beyond her creation. I said "seems like something negative repeatedly happens and that we need to keep meeting." She heard this somewhat clumsy remark to sound like her husband's complaints about her implying it is all her fault. She got angry and hurt, but did not tell me in the session. She talked about how hard it would be if she had to see another therapist. She wanted to know if I liked her but felt I did not. She was angry that I might leave sometime. The next day she called to say that she was stopping her medications. I suggested that stopping her medications was a way to break away from me and that she was angry at me. She agreed. We discussed her transference distortions. She did not stop her pills. When she returned for the next visit, she apologized. She had driven the hour drive by herself and reported great ease getting around her town. She recognized that she turned her anger against herself as suggested by her turning her

anger at me against herself by not taking medication. We discussed her perceptions of me. She also reported that should I leave she was willing to see someone else. In this case, a transference reaction became crystallized through medications and helped lead to a resolution.

Comment

Many psychotherapy researchers are turning away from "horse race" research (pitting one form against another) and are instead concentrating on microanalysis of critical psychotherapeutic interactions (17). Through the use of transcriptions of psychotherapeutic interactions, they are hoping to define the crucial components of psychotherapeutic change. Perhaps some microanalytic psychotherapy researchers might also attend to the manner in which the prescription and use of medications during psychotherapy may help or hinder the psychotherapeutic process.

Until then, psychiatrists are left with clinical anecdotes from their own experiences and the experiences of others. In this chapter, I have tried to demonstrate the reciprocal relationship between the use of medications during psychotherapy and the process of psychotherapy. Medication issues highlight the goals and difficulties of engagement and offer an additional perspective on psychotherapeutic patterns in need of change, including transference, resistance, and countertransference. Medications and their meanings may aid in the relinquishing of old patterns, the initiation of new patterns, and the maintenance of new patterns. Termination problems may also reveal themselves around the meaning and use of medications. On the other hand, psychotherapy understanding demonstrates that medications may function in ways far more complex than are suggested by the term *placebo*. Not only do they serve as active placebos (active medication plus the expectation and hope of symptom relief), but they function in ways that support and inhibit the development of the psychotherapeutic relationship and its objectives.

Using medications during psychotherapy is quite common in current psychiatric psychotherapy (18). Most often discussion of medications is reserved for the first few minutes or the last few minutes of a session and paid little attention outside of that time. As illustrated by the clinical vignettes of this chapter, sometimes medications may take on important psychotherapeutic meaning. Future work is required to sharpen our understanding of the reciprocal relationship between the use of medications and the psychotherapeutic process.

REFERENCES

1. Karasu TB: Psychotherapy and pharmacotherapy: toward an integrative model. Am J Psychiatry 139:1102–1114, 1982
2. Ostow M (ed): The Psychodynamic Approach to Drug Therapy. New York, The Psychoanalytic Research and Development Fund, 1979
3. Lesse S: Anxiety: Its Components, Development and Treatment. New York, Grune & Stratton, 1970
4. Sarwer-Foner GJ: An overview of combined psychopharmacology and psychotherapy, in Psychopharmacology and Psychotherapy. Edited by Greenhill MH, Gralnick A. New York, Free Press, 1983, pp 165–180
5. Gutheil TG: Drug therapy: alliance and compliance. Psychosomatics 19:219–225, 1978
6. Goldhamer PM: Psychotherapy and pharmacotherapy: the challenge of integration. Can J Psychiatry 28:173-177, 1983
7. Beitman BD: Pharmacotherapy as an intervention during the stages of psychotherapy. Am J Psychother 25:206–214, 1981
8. Beitman BD: Introducing medications during psychotherapy, in Combining Psychotherapy and Drug Therapy in Clinical Practice. Edited by Beitman BD, Klerman GL. New York, Spectrum, 1984, pp 65–88
9. Beitman BD, Goldfried M, Norcross JC: The movement to integrate the psychotherapies: an overview. Am J Psychiatry 146:138–147, 1989
10. Beitman BD: The Structure of Individual Psychotherapy. New York, Guilford, 1987
11. Klerman G: Combining drugs and psychotherapy in the treatment of depression, in Depression: Biology, Psychodynamics and Treatment. Edited by Cole J, Schatzberg A, Frazier S. New York, Plenum, 1976, pp 329–337
12. Klerman GL: The responsibility of the psychiatric profession (abstract), Proceedings of the American Psychiatric Association. San Francisco, CA, 1989, p 137
13. Frank J: Restoration of morale and behavior change, in What Makes Behavior Change Possible. Edited by Burton A. New York, Brunner/Mazel, 1976, pp 73–95
14. American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, 3rd Edition, Revised. Washington, DC, American Psychiatric Association, 1987
15. Epstein L, Feiner AH: Countertransference. New York, Jason Aronson, 1979
16. Langs R: Psychoanalytic Psychotherapy, Vol 1. Northvale, NJ, Jason Aronson, 1973
17. Rice LN, Greenberg LS: Patterns of Change. New York, Guilford, 1984
18. Beitman BD, Maxim P: A survey of psychiatric practice: implications for residency training. Journal of Psychiatric Education 8:149–153, 1984