

Psychodynamic Psychiatrists and Psychopharmacology

Joseph R. Silvio and Raúl Condemarán

Abstract: Over the past 20 years, the previously frowned upon combination of pharmacotherapy and psychoanalytic or psychodynamic therapy has become common practice because of both findings from the neurosciences that demonstrate hardwired brain development from chronic early stress and trauma and from efficacy studies that show the superiority of combined therapy over either psychotherapy or medication alone. With this shift has also come a more focused interest in the psychodynamics of pharmacotherapy itself. This article will review some of the current thinking in this area and then present the personal approaches toward pharmacotherapy of two psychoanalysts, one at an academic hospital (RC) and the other in private practice (JS).

We should begin by defining “psychodynamic.” Gabbard (2000), in his textbook *Psychodynamic Psychiatry in Clinical Practice*, offers the following:

Psychodynamic psychiatry is an approach to diagnosis and treatment characterized by a way of thinking about both the patient and clinician that includes unconscious conflict, deficits and distortions of intrapsychic structures, and internal object relations and that integrates these elements with contemporary findings from the neurosciences. (p. 4)

This can be further elaborated by Mintz (2009):

Psychodynamic psychopharmacology explicitly acknowledges and addresses the central role of meaning and interpersonal factors in pharmaco-

Joseph R. Silvio, M.D., Psychoanalytic Fellow of the AAPDP; Assistant Clinical Professor of Psychiatry, The Uniformed Services University of the Health Sciences; and Teaching Analyst, Washington Center for Psychoanalysis.

Raúl Condemarán, M.D., Psychiatric Member of the AAPDP; Clinical Instructor in Psychiatry and Medicine at Harvard Medical School; and Medical Director of the HARP Program at Mass. Mental Health Center.

logic treatment. This approach recognizes that many of the core discoveries of psychoanalysis (the unconscious, conflict, resistance, transference, defense) are powerful factors in the complex relationships between the patient, the doctor, and the medications. (p. 1)

The relevance of this focus on the psychodynamics of pharmacotherapy rests with the recognition of the importance of compliance and the placebo or nocebo effect in the effectiveness of psychotropics. Mintz (2006, 2009) points out that the effectiveness of medications seems far lower than expected, given the improvements in safety, specificity, and potency of newer agents, and he feels this may be due to the failure to appreciate unconscious psychodynamic factors that are at odds with patient improvement. Alfonso (2009) cites the high incidence of non-compliance with doctors' instructions. What appears to be the single most important factor determining pharmacotherapy outcome is a positive therapeutic alliance, and what most contributes to that is the psychiatrist's attention to psychodynamic factors such as the nature of the transference to both the doctor and the medication, conscious or unconscious preconceptions about medications, resistance to giving up symptoms that serve defensive or self-serving purposes, and counter-transference to the patient's character style.

A number of authors have addressed the psychodynamics of pharmacotherapy. Mintz (2006, 2009) focuses particularly on using psychodynamics to understand and better help patients who are treatment resistant and either do not respond to psychotropics or cannot tolerate them because of side effects, or who do respond with symptom relief but show no improvement in their quality of life. He points to the large contribution the placebo effect appears to have in psychotropic effectiveness and the enhancement of it by a positive therapeutic alliance that promotes the expectation that the medication and the doctor will be helpful. Correspondingly, the nocebo effect, which is heightened by expectations that the medication or the doctor will be harmful, can block or minimize any positive medication effects and exaggerate adverse reactions. Mintz (2006, 2009) encourages active interpretation of negative transference manifestations and of conscious or unconscious resistances to improvement. He also sees a focus on the psychodynamics of pharmacotherapy in supervising psychiatry residents as a way to introduce them to the importance and usefulness of psychodynamics which they may get little exposure to in their training.

Alfonso (2009) addresses the importance of developing a positive therapeutic alliance and using psychodynamic thinking within the constraints of contemporary practice, which often limits psychiatrists to prescribing only and during brief medication appointments. He

cites the example of family practitioners who manage to maintain such positive alliances with patients who they may see only once or twice a year, but over long periods of time, and believes that the same can be achieved with mandated brief and infrequent pharmacotherapy appointments. He notes the role of negative countertransference issues in the premature discontinuation of medications or in their over- or under-prescribing. He also points to research in the attachment field that indicates greater degrees of noncompliance in patients with dismissing attachment styles.

Forrest (2004) addresses an underappreciated aspect in the nature of the therapeutic relationship, and that is the patient's character armor. He assembles a detailed description of ten character styles and their expected transference reactions to both medications and how they are prescribed. He suggests that awareness of the psychodynamics of character preferences will assist the psychopharmacologist in developing a strategic approach to each individual patient that will heighten compliance and minimize noncompliance. He highlights the importance of patients' preconceived ideas about specific medications from what they have heard from the media or friends and family, and corresponding views of psychiatrists as agents of pharmaceutical companies who will try to push drugs on them. He believes that addressing these transference issues in the very beginning is crucial to the development of a positive therapeutic alliance.

Gabbard and Bartlett (1998) write about the role a psychodynamic psychopharmacologist prescribing medication in a split treatment can play in enhancing the progress of an analysis. In a case presentation, they highlight the importance of ongoing collaboration between the analyst and the psychopharmacologist (who in this case is also an analyst) to enhance and support each other's function. For example, the analyst is able to maintain a neutral attitude toward the patient's decision about whether or not to take medications and encourage the patient to take up questions and concerns directly with the psychopharmacologist, and the prescribing psychiatrist can more actively encourage the patient to explore with the analyst certain issues that appear to be impeding progress toward the treatment goals.

In their book *Competency in Combining Pharmacotherapy and Psychotherapy: Integrated and Split Treatment*, Reba and Balon (2005) address the needs of residency programs and psychiatry residents to achieve one of the six competencies mandated by the ACGME. They emphasize the importance of psychodynamics and the importance of a thorough diagnostic assessment, and encourage residents not to be pressured about time constraints but to take whatever time is necessary to complete this. They provide a list of suggestions for the pharmacotherapist to follow:

- The clinician should be constantly aware of the seduction of marketing.
- Psychodynamic formulations are not a luxury but are necessary for making good treatment choices and for evaluating and reevaluating (on an ongoing basis) drug choice and the effectiveness of combined treatment.
- Psychiatrists should not be intimidated by time pressures, especially in the early appointments.
- Discussions of chemical imbalances are generally less helpful than many clinicians think, because it is so difficult to predict what they will mean to any given patient.
- The clinician should neither oversell nor undersell any one drug as a part of the treatment regimen but should instead tell the patient that there are other choices.
- Psychiatrists should treat their patients as though the therapeutic relationship matters more than the pills- because it usually does. (p. 107)

PSYCHODYNAMIC PSYCHOPHARMACOLOGY IN PRIVATE PRACTICE

Joseph R. Silvio, M.D.

How does the psychodynamic psychiatrist apply these principles in his/her role as psychopharmacologist? As someone who has been in private practice for 35 years, who was trained at a psychodynamically oriented residency program and a fairly classical psychoanalytic institute, and whose interest in finding better fits between clinical experience and theoretical understanding led to explorations of self-psychology, neuroscience, infant research, and attachment theory, I have found integrating psychodynamics with pharmacotherapy invaluable. I would like to share some of my experiences with you.

First, as Gabbard (2000) points out in his description of dynamic psychiatry, it is an approach to diagnosis and treatment. So I always start with making it clear to my patients or those referred for medication consultations by nonpsychiatrist colleagues that I will be conducting a comprehensive psychiatric evaluation as the foundation for my assessment of the suitability of medication for their situation and that this will involve one or more 45- to 60-minute sessions and not simply a brief 15- to 30-minute appointment. I explain the need for this as resting in my belief that each person is unique and the difficulties they are

experiencing can only be understood in the context of their individual life histories and emotional concerns. Most people are reassured by this approach, since it lets them know that I am taking the prescription of a psychotropic medication as seriously as they do, and that they will have some time to get to know me as I get to know them, which allows for the development of trust. This enhances later compliance with medication instructions should a medication be recommended. I have also found that referring colleagues will not infrequently ask for my diagnostic assessment of their patients in addition to medication recommendations, since the consultation was often prompted by the persistence of symptoms unresponsive to their current treatment approach. It has also been my practice to initially not ask the referring therapist for any detailed information about the patient's history or diagnostic formulations, beyond the reason for the consultation. This allows me to minimize preconceptions about the patient, and eliminates the patient's concern about how much I already know about them that they do not have to repeat. I usually begin a medication consultation by asking patients what their understanding is of the reasons for the referral and then how they feel about it. Not infrequently, there is significant ambivalence, especially for people who have not been on psychotropics before. I feel it is important to address this at the beginning of the evaluation to remove as much as possible unspoken negative feelings that can increase defensiveness and guardedness during the history taking.

Once this matter is addressed, I will make a decision about how next to proceed based on my sense of what will best promote a positive and collaborative working alliance. What I will want to cover will be the nature and history of the patient's psychiatric disorder; the specific symptoms the patient and referring therapist are hoping medication will relieve; the past and family history, including multigenerational experiences of psychiatric disorders, losses, or traumas that may have genetic or attachment implications; past and current medical history, especially for childhood illnesses that may have been traumatic or caused prolonged early separations; relational and sexual history; and mental status assessment. The order in which I will take up these matters depends on the individual patient. For patients who seem eager to be given a pill to relieve specific symptoms, I'll ask for details about what those specific symptoms are, how long they have had them, when they began and what was happening in their lives at the time, and what they have already tried to find relief. For patients who are unsure if they want to take medication or not, I will usually start by asking them to tell me about their problems in a more open-ended way, then segue into asking them to tell me about themselves, their families, and their life histories. For patients who are very focused on somatic symptoms, I begin

with a more medically oriented approach, including a detailed inquiry into their physical concerns, the extent of their medical evaluations, and a comprehensive medical history. Regardless of the preponderance of data favoring a psychological etiology for the physical symptoms, I usually recommend whatever medical tests have not yet been done after reviewing the case with the patient's other physicians. Although the chances of finding an organic cause is usually very small, ruling out that small possibility does much to reduce the use of that uncertainty as a defense against acknowledging the psychological nature of the symptoms for the patient and as a cause of doubt in my own mind. I try to start with where the patient is and put my agenda secondary to the establishment of a positive therapeutic alliance, although sometimes I misread the situation with the expected negative outcome.

After gathering all the information I can, I will try to summarize the important details of what we discussed and ask if I've gotten things right so far. If the situation is very clear, or if the patient is in acute distress, I will try to offer my understanding of the cause and nature of their symptoms and give my opinion of whether or not medication might be useful to them. If I believe it would be, I then outline the different medication options with their individual benefits and side effects. I always encourage patients to ask any questions they might have at this point and to take as much time as they need to decide how they would like to proceed. I will usually offer to provide the names of several websites where they might find unbiased information about the medications mentioned. When possible, however, I usually prefer to have a chance to talk with the referring clinician, obtain any needed medical evaluations, and take time to think through the case before making any recommendations, which I like to present at a follow-up session. When assessing adolescents, I usually meet separately with the parents to obtain the patient's early childhood history and to get a more detailed family history as well as a more accurate picture of the family dynamics. Whenever diagnostic factors remain uncertain, I strongly recommend psychological testing, especially when suspicious of an underlying thought disorder or bipolar disorder that might be obscured by oppositional behavior, drug use, or unconventional traits.

When a trial of medication is decided upon, I turn to the construction of a symptom check list for the purposes of identifying more precise target symptoms that can be tracked over time for response to medication. I try to make this a collaborative process by asking the patient to imagine that we could construct a medication just for them and then to tell me exactly what they would like this medication to help them with,

regardless of whether that seems realistic or not. After getting the patient's list, I will then suggest adding those symptoms not yet included that I would expect a medication to effect. In a patient with depression, for example, I would want to be certain that suicidal ideation, mood, cognitive function, energy level, sleep and appetite status, and sexual interest and function were included. Once the list is assembled, I then ask the patient to give me a severity rating on a 0–10 scale, with 0 being no problem and 10 being the most severe imaginable. This check list is rated at each follow-up session and helps both the patient and me to monitor the effectiveness of the medication and its side effects over time and dose adjustments. I try to keep the referring clinician informed of my assessment and impressions after each medication appointment and ask for feedback on the case.

In following this procedure, I have diagnosed unidentified thought disorders in two adolescents, one whose school failure was attributed to his depression, which was actually secondary to his inability to focus and concentrate because of covert delusions, and another whose social isolation and academic underachievement were seen as symptoms of her anxiety disorder which, in fact, resulted from her confusing and upsetting loose associations that drove peers away and undermined her academic performance. I have also uncovered the traumatic origins of “genetic” anxiety and mood disorders ascribed to “chemical imbalances” when the affect around severe illnesses or losses was split off and isolated from their memories.

Equally important to knowing what to prescribe is knowing how to prescribe it. For example, with someone who identifies their problem as a simple depression and denies the bizarre nature of their thinking because of the fear there is something seriously wrong with them, starting with a recommendation for a trial of an SSRI (serotonin selective reuptake inhibitor) will be more helpful than initially recommending an antipsychotic, which might well rupture any therapeutic alliance. Once the alliance has been strengthened by collaborative work with monitoring the effects of the antidepressant, a recommendation to add an antipsychotic is more likely to be heard in a receptive manner.

Perhaps the most useful rule I follow in psychodynamic pharmacotherapy is to conduct the process the way I would wish to be treated if the situation were reversed.

**PSYCHODYNAMIC PSYCHOPHARMACOLOGY
IN AN ACADEMIC HOSPITAL****Raúl Condemarín, M.D.**

I would like to present the perspective of a psychodynamic psychiatrist working in an academic hospital. My initial practical training after medical school was in internal medicine, when I worked as a family physician in impoverished rural communities in Northern Peru. Later, after coming to the U.S., I received formal training in psychiatry, psychoanalysis, addiction psychiatry, and psychosomatic medicine. I currently work as an Attending Psychiatrist in a teaching hospital that belongs to the public sector.

This era of managed care and brief encounters with patients is characterized by the pursuit of quick relief to complex problems by both the medical system and its patients. It is not uncommon to find that in hospitals, the initial approach to complex situations in mental health is the immediate prescription of medications. Important psychodynamic factors that are involved in the relationship between patient, doctor, and medication are frequently ignored, to the detriment of the overall quality of care and ultimate clinical outcome.

Patients seen in academic hospitals differ somewhat from those seen in private practice, especially in their level of complexity, but the principles to treat them are the same. Many are referred to academic centers from community mental health centers with the diagnosis or label of "treatment resistant," while others are called "high risk" because of their history of multiple suicide attempts. From inpatient units, we receive referrals for outpatient follow up of patients recovering from an acute crisis. The majority of these patients had multiple hospitalizations and have been on several medications, with different degrees of compliance. Patients with multiple *DSM* Axis I diagnoses and comorbid substance abuse or dependence, especially to alcohol, stimulants and opioids, are also common in academic hospitals. These conditions are important to be considered and treated in order to improve compliance with pharmacotherapy.

Most of the time, a complete and detailed psychiatric evaluation of 60–90 minutes will help us to clarify the diagnosis, learn how the person related to prior mental health providers, and identify any medical issues. Patients with diabetes, obesity, hypertension, hepatitis C, liver disease, hypercholesterolemia, seizure disorder, and metabolic syndrome are seen very often in hospital populations.

Patients with depression and diabetes who have sexual dysfunction frequently do not disclose this to their psychiatrist. They are often prescribed SSRIs to avoid adverse interactions with other medications, which can exacerbate sexual dysfunction and become a factor for non-compliance and impairment of the therapeutic relationship.

Polypharmacy with psychotropic medication is another characteristic noted in patients referred to us from other hospitals. In addition, patients are often prescribed excessively high doses of medication in order to treat unresponsive symptoms, which provoke more side effects, further hindering the goals expected. This challenges the prescriber to remain current with dosage indications and pharmacologic interactions, as well as with new or established alternatives to those medications being used.

Personality disorders or personality traits are also important to consider in the academic hospital population. In the first psychiatric evaluation, it is often not easy to detect if a patient has a personality disorder, so this is something that needs to continually be assessed in following sessions. A careful and systematic psychiatric history is essential to reaching an appropriate diagnosis and determining a future treatment plan. Patients with personality disorders like borderline, histrionic, narcissistic, or antisocial are often followed in hospital settings. Such patients have significant impairments in interpersonal relationships that make difficult the formation of a therapeutic alliance, while fostering countertransference reactions in us that negatively impact the therapeutic relationship. I consider it very important to pay attention to the way the patient relates to doctors and to medications as reflected in their experiences with prior medication regimens.

In academic hospitals, many patients are being followed by medical residents, who bring to supervision their concerns about their patients' problems with noncompliance, treatment resistance, development of intolerable side effects, and defensive attachments to medication. The residents' first approach to these problems often is to increase doses, change medications, or add another psychotropic medication in order to solve the problem. It is at such times that having a psychodynamic psychopharmacologic approach can help us to explore the different factors behind the noncompliance and treatment resistance involved in the complex process of prescribing medication. I believe that this integrative psychodynamic psychopharmacologic approach should not be limited to treatment resistance or noncompliance, but should be applied in any scenario that involves the use of medication.

Despite the growing emphasis in biological treatments and short-term therapies, these approaches often fall short of expected results. Psychiatry residents in academic hospitals are exposed mostly to psy-

chopharmacology, research, and supportive or brief therapies, with only a few residency programs offering training in psychodynamic therapies. The new generation of residents has a strong background in neuroscience and biological treatment, but still must struggle with treatment resistance and poor medication compliance in their patients. I strongly support teaching and supervision of psychodynamic pharmacology that can introduce residents to a psychodynamic approach that demonstrates the usefulness of working with transference, counter-transference, and defenses involved in the therapeutic relationship of the pharmacotherapy component of psychiatry.

In my experience working with residents in supervision, using this psychodynamic psychopharmacological approach has improved treatment outcome as well as the therapeutic alliance. This integrative approach allows residents to understand the complexity of prescribing medication, which involves more than "hitting" one receptor or another, but also "hitting" psychodynamic factors that modify defense mechanisms and elicit more adaptive transferences in the patient–doctor relationship. This integrative approach when used in the right way becomes an important clinical tool for developing clinicians.

I would like to present a brief case report of a patient with new onset of severe insomnia. We will call this patient Maria and disguise other factors for reasons of confidentiality. Maria is a middle-age Latino woman, married for 30 years and mother of two grown children. She has a history of Bipolar I disorder and recently began experiencing severe insomnia. She is being followed on an outpatient basis and has not had a psychiatric hospitalization in the last ten years. Her medications include lithium carbonate 900 mg qhs, trazodone 200 mg qhs, and lamotrigine 200 mg qd. She has shown good compliance with this medication regimen, which she has been taking for many years without any adverse effects. Maria has no history of substance use and is being followed up by her primary care physician for hypertension, hypercholesterolemia, and mild obesity.

After being stable for many years Maria suddenly developed increased anxiety, mild tremors, and insomnia. During her psychiatric evaluation these symptoms were confirmed, but she did not show any symptoms of mania, hypomania, or depression. Her lithium level was found to be 1.1 meq/L, which was higher than her usual stable levels for several years of between 0.7 to 0.8 meq/L. The evaluation also revealed that Maria had been given an angiotensin-converting enzyme (ACE) inhibitor for hypertension by her primary care physician, and, due to medical interaction between lithium and ACE inhibitors, her lithium level had increased. Maria's symptoms of anxiety and tremors

improved after the hypertension medication was discontinued, but her insomnia gradually became worse.

Maria reported that she was feeling tired at night but was unable to sleep when she was in bed. She requested that her dose of trazodone be increased to help her to sleep and also reported that she had taken over-the-counter medication for insomnia for several weeks but had discontinued it because she did not improve. A sleep study and medical workup were ordered to rule out other causes of her insomnia. All the tests were negative. She denied the use of stimulants or caffeinated beverages. It was determined that Maria's severe insomnia was not related to Bipolar Disorder, medical reasons, or any medication interactions.

After establishing that there was no organic reason for her insomnia and knowing she had always been compliant with medication, I looked into possible psychodynamic factors for Maria's insomnia. Since Maria has a positive therapeutic relationship with me, I decided to see her more often to explore with her the sudden loss of effectiveness of insomnia medication she had used successfully for many years. She reported she had been "thinking too much" about her marital relationship when in bed. Maria had undergone a hysterectomy for uterine fibroids a year prior, and since then she was having less and less sexual relations, which had now stopped completely for 3 months. Despite her normal libido, Maria was not having sex.

Maria's husband is ten years older than her and has been coming home from work late at night, uninterested in any sexual contact with her. Maria has been blaming herself for becoming unattractive to him because of having no uterus. She also feared that her husband was having an extramarital affair. These troubling thoughts had been occurring mostly at bedtime for the past several months. As Maria's insomnia increased, she self-medicated with pills provided by her family and also by increasing the dose of trazodone, which made her feel sedated during the day. She also reported that the extra sleep medication that she took made her gain weight and become irritable, while not helping her sleep.

During therapy sessions the marriage problems were discussed, as was the lack of sexual contact, and a recommendation for couples therapy was made. In couples therapy it was discovered that Maria's husband was having sexual dysfunction, which underlaid his sexual disinterest. As therapy progressed, Maria's insomnia started improving, and her sleep medication was slowly decreased and eventually stopped.

In treating Maria, I took into consideration multiple factors, including her cultural background and beliefs. Although she was bilingual in English and Spanish, she preferred having our therapy sessions in Spanish. I realized that Maria had a dependent personality and had developed a negative transference toward her primary care physician after having adverse effects from the medications he had prescribed. Keeping in mind the complex relationships between patient, doctor, medication, and the interface with cultural beliefs, I attempted to create a positive therapeutic alliance by respecting her desire to use alternative medicines, introducing new medication in low doses to minimize side effects, taking time to discuss potential side effects and the way that medication works, and using simple terminology and metaphoric expressions. These simple strategies helped Maria understand our treatment plan better and increased our therapeutic alliance, a most important predictor of good treatment outcome.

CONCLUSIONS

Our experiences in two very different practice settings have brought us to the same conclusion. A psychodynamic approach to pharmacotherapy can enhance initial diagnostic assessment and treatment plans, and help manage treatment resistance or nonresponsiveness. This approach puts great emphasis on the establishment of a strong positive therapeutic alliance, which begins with a genuine respect for the uniqueness of the individual and his/her life experience and internal world. It regards obstacles to treatment progress as defensive strategies devised to manage internal conflicts, negative transferences or countertransferences, or maladaptive underlying assumptions about medications, doctors, and mental illness. We also share a belief in the importance of teaching psychodynamics to psychiatry residents and demonstrating its utility through supervision, not only of psychodynamic psychotherapy, but also of psychodynamic psychopharmacology.

REFERENCES

- Alfonso, C. (2009). Dynamic psychopharmacology and treatment adherence. *The Journal of the American Academy of Psychoanalysis and Dynamic Psychiatry*, 37(2), 269-286.
- Forrest, D.V. (2004). Elements of dynamics II: Psychodynamic prescribing. *The Journal of the American Academy of Psychoanalysis and Dynamic Psychiatry*, 32(2), 359-380.
- Gabbard, G.O. (2000). *Psychodynamic psychiatry in clinical practice* (3rd ed.). Washington, DC: American Psychiatric Press.
- Gabbard, G.O., & Bartlett, A.B. (1998). Selective serotonin reuptake inhibitors in the context of an ongoing analysis. *Psychoanalytic Inquiry*, 18(5), 657-672.
- Mintz, D. (2006). Psychodynamic Trojan horse: Using psychopharmacology to teach psychodynamics. *The Journal of the American Academy of Psychoanalysis and Dynamic Psychiatry*, 34(1), 151-161.
- Mintz, D. (2009, July 27). Psychodynamic psychopharmacology: Addressing the underlying causes of treatment resistance. *Psychiatric Times*, 26(8). Retrieved from <http://www.psychiatrictimes.com>
- Riba, M.B., & Balon, R. (2005). *Competency in combining pharmacotherapy and psychotherapy: Integrated and split treatment*. Washington, DC: American Psychiatric Publishing.

Corresponding Author:
 Joseph Silvio, M.D.
 4400 East West Hwy #622
 Bethesda, Maryland 20814
jrsilvio@aol.com

