A Psychodynamic Perspective on Treatment-Refractory Mood Disorders

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Treatment successes can be hampered by treatment-refractory mood disorders. Nine key concepts are outlined to help guide the treatment of these patients.

Preliminary findings from an ongoing naturalistic, longitudinal study of treatment outcome support the notion that work with patients who have treatment-refractory mood disorders is enhanced by the careful integration of a psychodynamic therapeutic approach into the customary biological approaches. Review of a series of cases led to the identification of nine core psychodynamic principles associated with good outcome in these cases.

Advances in the treatment of patients with mood disorders have led to the recognition that about half these patients fail to respond adequately to biological treatment approaches (Fava and Davidson, 1996). Only a minority of patients recover fully with medications (Rush and Trivedi, 1995). Augmentation strategies and the use of algorithms to maximize therapeutic response in patients with mood disorders have emerged, but a subset of patients remain refractory to treatment. Treatment for these patients often becomes chronic crisis management, organized around fending off the next crisis or recovering from the last, with suicide attempts, repeated hospitalizations and significant strain on treaters.

Thase and colleagues (2001) suggested including a psychosocial component in treating these patients. However, their psychosocial approach does not include such central psychodynamic concepts as the role of unconscious mental processes or transference and countertransference and how they may relate to treatment-refractoriness.

This article offers a set of psychodynamic principles for working with patients with treatment-refractory mood disorders. The principles were derived from a study of patients with treatment-refractory mood disorders treated at the Austen Riggs Center, a national referral center for patients with treatment-refractory disorders. The Riggs continuum of care includes individual psychodynamic therapy four times a week and a sophisticated milieu program within a completely open setting. Treatment averages seven months in duration. Riggs is conducting an ongoing, naturalistic, longitudinal follow-along study of patients during and after treatment. The study uses reliable measures of symptom change, but also reliable measures of such psychodynamic constructs as defenses and conflicts.

Christopher Perry, M.D., M.P.H., and I now have data on the first 57 patients with three to five years of follow-up. Eighty percent of patients in the sample had reliably diagnosed mood disorders. The patients were a disturbed group, with 40% having six or more self-destructive episodes, 50% having made at least one serious suicide attempt, and 60% with three or more previous hospitalizations. Close to half the patients had histories of childhood trauma, while an increased frequency of trauma was associated with a greater number of Axis I disorders. Eighty-six percent of the patients had personality disorders, usually borderline personality disorder.

Preliminary findings suggested significant improvement over three to five years, with most of the change occurring after the first two years. Conservatively estimated effect sizes ranged from 0.4 (for self-report measures), to 0.5 to 1.0 (for employment, defenses and the Hamilton Rating Scales for Anxiety and Depression [HAM-A, HAM-D]) to 1.5 (for Global Assessment of Functioning [GAF]). Based on the evidence that these patients were improving, evidence from the literature (Bremner, 1999; Kaufman et al., 2000) and clinical experience suggesting that character issues play a role in treatment-refractoriness, I undertook a review of such cases to discern psychodynamic principles associated with good outcome.

The principles were extracted from cases studied by direct review of the medical records, supplemented by my participation in extended case conferences and/or serving as psychotherapy supervisor. In two cases, the review was based on my own reassessment of the medical records of patients I had treated in the past. This methodology is limited by my own unwitting clinical biases,
but it is a reasonable starting point for such a complex endeavor. A summary of the psychodynamic principles follows. **Consider Diagnostic Comorbidity**

Our experience confirms clinical experience that patients with treatment-refractory mood disorders often present with complex comorbidity, making them unlike the patients generally included in medication trials (Perry et al., 2001). Our first 57 patients met criteria for an average of six Axis I and II disorders. Eighty-six percent met criteria for one or more personality disorders, 70% had underlying dysthymia, 41% had substance abuse problems, and 36% met criteria for posttraumatic stress disorder (PTSD). **Implement an Interdisciplinary Treatment Plan**

Patients with complex comorbid clinical presentations require an interdisciplinary treatment plan. Medication, psychotherapy, family work, substance abuse treatment, group work, case management services and medical management may all be required, regardless of the treatment setting. Often a different clinician provides each service, creating a de facto treatment team. When there is such a team, communication is essential. This is particularly important in cases with prominent Axis II pathology because of the frequency of splitting and projective defenses. Team members may find themselves split in ways that reflect and, potentially, illuminate the patient's life history (Shapiro and Carr, 1991). Patients with good outcomes generally had treatment teams that used a psychodynamic formulation to notice and integrate splits, while deepening understanding of the patient. **Carefully Negotiate the Therapeutic Alliance**

In psychodynamic treatment, the alliance includes negotiation of an agreement to explore the patient's mind and the meaning of their actions, verbalizations and symptoms. It also includes careful delineation of the roles and responsibilities of therapist and patient. Therapists of patients with treatment-refractory mood disorders who had good outcomes made the alliance the foundation on which the rest of the treatment was built. Particularly when Axis II pathology complicates treatment of a mood disorder, acting-out and assaults on the boundaries of the treatment often unfold. A clearly negotiated alliance, in the face of a strong transference attachment, helps contain acting-out within the therapy instead of spilling over into the patient's life (Plakun, 1994). This can avoid chronic crisis management during therapy sessions. **Listen To What Lies Beneath the Symptoms**

This recommendation is derived from the notion that character contributes to treatment-refractoriness and that character is revealed in repeated and unwitting utilization of particular defensive patterns. Our best access to this material comes from listening to what lies beneath our patients’ symptoms with a psychodynamic ear. We listen to affect and follow where it leads, empathically framing and linking together a narrative of the patient's life, while noting central repeating themes and metaphors that recur in the present. In patients with good outcomes, this way of working deepened the alliance and introduced unique, individual meaning to a patient's experience of treatment-refractoriness. Sometimes it illuminated unconscious incentives for treatment-refractoriness. Sometimes it illuminated unconscious incentives for treatment-refractoriness. Sometimes it illuminated unconscious incentives for treatment-refractoriness. **Integrate Medication and Therapy**

Mintz (in press) has described three relevant areas for integration: medication compliance, placebo and negative or nocebo effects, and management of countertransference. Medication noncompliance is a widely recognized cause of treatment failure. Integrating a psychodynamic perspective into prescribing involves inquiring about the patient's subjective experience of the medication. Although we prescribe medication for its beneficial effect, patients perceive all the effects as coming from us, including adverse ones. Medication may also have unique personal meanings for patients. Mintz suggested that addressing noncompliance at the level of the specific personal meaning for the patient can improve compliance.

Most clinicians understand that the placebo effect accounts for a portion of the therapeutic effect of psychoactive medications. However, some patients are predisposed to experience nocebo, rather than positive placebo effects. Nocebo effects may be particularly common in patients with trauma histories or those with significant Axis II pathology. This latter group has been shown to have a high frequency of unconscious struggles with authority (Vereycken et al., 2002). These struggles often underlie the nocebo effect. Mintz (in press) also noted that treatment-refractory patients may induce frustration and despair in their prescribers. As a result, prescribers may unwittingly respond to patients with withdrawal or a sadistic countertransference response. Psychodynamic understanding of these countertransferences can help prescribers maintain therapeutic neutrality.

These points are illustrated by the case of a 39-year-old woman with a treatment-refractory, chronic major depressive disorder with psychotic features comorbid with anorexia nervosa, PTSD and borderline personality disorder. This patient had failed many medication trials, although some relief had been obtained with phenelorine (Nardil). The patient's severe suicidality, medication
noncompliance, repeated pill-hoarding and pattern of overdoses made it difficult to trust her to follow the monoamine oxidase inhibitor diet or to refrain from overdosing on agents that interact with MAOIs. Her psychiatrist experienced understandable countertransference feelings of anger, and a sense of frustration, despair and defeat. Responses sometimes included becoming overtly angry and scolding the patient or otherwise responding sadistically. At one point, the work had moved along enough that her experience of childhood sexual abuse could be explored. The psychiatrist/therapist learned that her childhood sexual abuse had included forced oral rape. The therapist suddenly realized where the medication noncompliance, hoarding and overdoses came from. He framed an interpretation that stated his new learning: "What an awful experience. I know it was hard for you to speak about, but it has helped me realize something about why medications are such a difficult issue for you. You can't allow me, or anyone else, to control what gets put into your mouth without it feeling like submitting to oral rape again."

The patient was moved by her doctor's empathic grasp of the problem and was subsequently able to stop hoarding pills and overdosing and undertook a trial of phenelzine while following the MAOI diet. Although this did not end the patient's difficulties, addressing problems of compliance and medication-hoarding at the level of meaning for the patient improved the treatment alliance and made some symptom relief possible. **Transference, Countertransference and Enactment**

Transference, countertransference and enactments are central psychodynamic concepts and inevitable therapeutic phenomena. Patients recreate with treaters powerful issues from past family and other relationships. They repeat in the present past events that are not remembered. We respond to transference with countertransference, which has two components. One component is the reaction anyone might have to the patient, while the second is shaped by our own early life history, characterologic predispositions and blind spots. Sometimes the patient's transference hooks a particular vulnerability, and we not only experience the countertransference, but also act it out. This inevitable therapeutic phenomenon is called enactment (Plakun, 1999) and is particularly common in patients with Axis II disorders who often employ projection as a defense. Therapists whose patients had good outcomes were skilled at attending to transference, countertransference and enactments to deepen therapeutic work. **Find the Affects That Are Out of Consciousness**

Many patients with treatment-refractory mood disorders comorbid with Axis II pathology and/or trauma present in ways that suggest feelings are missing from the patient's awareness. An example is the repeatedly suicidal patient who lacks awareness of the terrifying and aggressive impact a suicide would have on family members, friends or treaters. Such patients are often struggling with affects that they can neither contain nor process. Such feelings often remain out of conscious awareness but are encoded in actions. Therapists whose patients improved demonstrated an ability to help patients find and put into words unavailable affects. This was facilitated by attending to countertransference and enactments. **Use Everyday Language To Make Interpretations**

Effective, well-timed interpretation helps the patient take charge of their life by replacing repetition of what cannot be remembered with memory and meaning. Therapists whose patients improved made interpretations in everyday language that came from the identified themes and metaphors that emerged in listening to the patient's life history. Interpretations show the patient how they are unwittingly repeating something they are not in charge of. They offer the patient the opportunity to slow down rapid-fire actions, put them into words, and remember and put them into perspective. Therapists whose patients improved also kept an interpretive focus on what they had learned about the underpinnings of the patient's treatment-refractoriness. **Use Psychotherapy Consultation**

Psychiatrists faced with a patient with a treatment-refractory mood disorder often turn to colleagues for advice about additional biological interventions. Outside perspectives also proved useful with psychotherapy, regardless of the experience level of the therapist. Outside perspectives can help detect and untangle enactments and also help resolve impasses that may be associated with treatment-refractoriness. These outside perspectives may also be useful in reaching recognition that a change of therapist is indicated.

Patients with treatment-refractory mood disorders present a significant challenge to clinicians. Preliminary data from an ongoing, naturalistic, longitudinal study of treatment outcome suggest those patients who present with complex comorbidity, including histories of trauma and prominent Axis II pathology, benefit from addition of a psychodynamic therapeutic approach.

References: References

2. Fava M, Davidson KG (1996), Definition and epidemiology of treatment-resistant depression.


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