Combining Psychopharmacology, Psychotherapy and Psychoanalysis

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By Fredric N. Busch, MD [1] and Barnet D. Malin, MD [2]

The advent of safer psychopharmacological agents with less troublesome side effects, along with increasing knowledge of the broad array of syndromes treatable with medication, have led to a vast expansion in treatment options available to the psychiatrist. Studies and clinical experience demonstrate that employing psychotropic medication in combination with psychoanalysis or psychodynamic psychotherapy now occurs with increasing frequency.

Two recent studies at the Columbia University Center for Psychoanalytic Training and Research indicate the degree of this trend. A survey of training analysts revealed that they had prescribed medication to 20% of their analytic patients in the preceding five years (Donovan and Roose, 1995), while a survey of candidate training cases showed that 30% of their patients were taking medication (Roose and Stern, 1995).

The process of integrating psychoanalytic and psychodynamic treatments with psycho-pharmacology therefore deserves continued study. In many instances, the combination can function synergistically, with psycho-pharmacological interventions aiding the patient's ability to pursue psychoanalytic investigation; these investigations in turn articulate the meaning and impact of taking medication to the patient and therapist (Busch and Auchincloss, 1995).

However, medication and psychodynamic approaches can be in conflict, both clinically and theoretically. The process of learning to work with such different listening frameworks, data sets and technical approaches is therefore quite challenging. The journal *Psychoanalytic Inquiry* has devoted an upcoming issue to the exploration of these topics, and many of the following ideas are from that issue.

Analytic Bias Against Medication

Controversies about combining psychoanalysis and medication have been present for many years. They arose, in part, from the way in which psychoanalysts employed metapsychological theories to explain both character pathology and major psychiatric conditions. Although the substance of these theories varies between psychoanalytic schools of thought, they all examine psychiatric illness in terms of psychodynamic factors. Conflict arises when a psychodynamically based explanation of a medical condition is construed as its etiology (Roose, 1997; Roose and Johannet, in press; Malin, in press). This leads to an unjustified view of medication as affecting only secondary or peripheral symptoms.

This line of thinking has prompted some psychoanalysts, particularly in past decades, to eschew the use of psychotropic medication altogether. Historically, psychoanalysts have viewed medication as an interference in the development of the transference in psychoanalysis, although sometimes necessary to control symptoms adequately to permit the psychoanalytic treatment to continue. Additionally, medication was felt to reduce anxious and depressive affects that were important motivators for treatment. **Organic Substructure**

Yet this view of physiology as secondary is curious in many respects. Constitutional and biological contributions to psychiatric illness are acknowledged throughout the psychoanalytic literature. In fact, Freud (1914) believed that "all our provisional ideas in psychology will presumably some day be based on an organic substructure" and that his metapsychological theories were only speculative concepts meant to be replaced by the emergence of newer, better explanations.

From this point of view, psychoanalysts who explain psychiatric illness by metapsychological theories alone make the epistemological error of transforming this one perspective into a complete...
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system of theory and technique that then cannot admit of any alternative or adjunctive viewpoints. The same may be said of psychiatrists who employ biological theories exclusively to explain all of their patients' positive and negative responses to medication treatment, or who believe that concepts such as neural Darwinism will eventually explain character type and pathology, obviating the need for psychodynamic treatments. There has been some shift in the above analytic perspectives. Nonetheless, psychoanalysts continue to struggle with them. Psychoanalysts sometimes have the reflexive concern that when medication is prescribed, the treatment they are performing is no longer psychoanalysis. This may consciously or unconsciously cause an avoidance of medication in situations in which there is a clear indication to consider a trial of medication. Another potential pitfall for analysts is giving too much weight to the meaning of symptoms rather than phenomenology in making medication decisions (Roose and Johannet, in press).

Once it has been determined that medication and psychodynamic treatments should be combined as clinically indicated, a number of questions arise. Which treatments should be used under what particular circumstances? How should varying technical stances with these treatments be managed? Who should prescribe the medication?

With regard to choice of treatments, Roose (1997) emphasized the importance of making medication decisions based on phenomenology, since that is the source of data that studies of medication effectiveness employ. However, case reports of psychodynamic psychotherapy and psychoanalysis, as well as systematic studies of other psychotherapies indicate that biologically based syndromes can respond to psychotherapy.

The clinician that states that medication was used because the symptoms did not respond to interpretation may leave out the possibility that the symptoms may have responded to interpretation in the hands of another psychoanalyst, or that the directive stance adopted for the use of medication prevented the intensification of the transference necessary for symptom relief.

In addition, psychopharmacological treatment may interfere with the patient's motivation to address more long-term characterological issues. Most clinicians have had cases in which the patient's improvement on medication has led to the patient's wish to reduce the frequency of visits or terminate treatment. Whether this is a "good" or "bad" outcome depends on the particular features of the case. In some instances, adequate or significant improvement in the patient's symptomatology may obviate the need for intensive psychotherapy or psychoanalysis. For other patients, it may be difficult to achieve further gains via insight-oriented psychotherapy because the patient is not well suited for it. In other instances, however, the loss of motivation can represent a flight from struggling with maladaptive traits that can lead to ongoing disruptions in psychological functioning and vulnerability to recurrence of symptoms on or off medications. Technical Issues

Significant differences exist between psychodynamic and psychopharmacological clinical techniques due to the different methods of gathering information and the types of interventions being made. An analyst or dynamic psychotherapist may thus have difficulty or feel awkward when shifting between one approach and the other, and the patient may find these changes confusing.

While many therapists believe that such maneuvers can be done effectively, others believe that the active intervention of prescribing medication, either by the therapist or a consulting psychopharmacologist, can lessen the intensity of the transference and thus blunt and impair the most powerful psychodynamic tool for producing clinical improvement. The prescribing state of mind may also covertly heighten directive, authoritarian, and omnipotent countertransference responses on the part of the physician psychotherapist and psychopharmacologist, adversely affecting the treatment and transference as well.

Consulting Issues

Managing these technical difficulties may be either facilitated or worsened by having a consulting psychopharmacologist prescribe the medication. Some physician analysts believe that referring the patient to a colleague for medication actually clarifies the transference, improving and preserving the analytic process as a result.

Other physician analysts feel that prescribing the medication themselves will enhance the total treatment because of the ability to know the patient more completely, to monitor the physiological impact of the medication more closely, and to assess more completely the patient's psychological reactions to these impacts as well as side effects. The presence of a "third party" in the treatment introduces a complicating array of transference and countertransference responses between the members of this therapeutic triangle (Busch and Gould, 1995).

The working relationship between a psychopharmacologist and a dynamic psychotherapist or analyst may be structured in various ways and therefore requires examination. While most practitioners
argue for close communication and contact between the two (Gould and Busch, in press), others believe that as little contact as possible preserves the analyst's neutrality more effectively, which aids the therapeutic process. According to Kelly (in press), an "abstinent" model calls for the physician analyst to refrain from prescribing medications because it would interfere with the analytic function in this specific dimension. Within this model, the analyst limits communication with the consulting psychopharmacologist as much as possible and examines the psycho-pharmacological treatments as a development in the patient's life just like any other.

**Shifting Gears**

Listening to a patient for both psychopharmacological and psychoanalytic data is not an easy task. The clinician tends to get involved in a certain mode of listening and a certain pattern of data gathering. The clinician in the fourth year with a patient in analysis is going to be far less likely to ask about vegetative symptoms than he or she would in the initial evaluation. Cabaniss (in press) proposes that, from a clinical standpoint, the prescribing psychoanalyst must "shift gears" between psychodynamic and psychopharmacological frames of reference when assessing and treating patients. The therapist can shift the conceptual framework for evaluating the clinical data between the dialectical poles of psychopharmacological and psychodynamic perspectives. Considering the weight of the evidence in both dimensions concurrently, the therapist attempts to determine if interpretive, psychopharmacological or simultaneous interventions are appropriate to the immediate clinical situation. For instance, the patient who suffers from guilt when improving on medication may associate a sense of increased potency with damaging, hurtful behavior or fantasies toward others, or the persistent guilt may be evidence of a partially resolved depression. Considering the weight of the evidence, the therapist can interpret the patient's conflicts, increase the dose of medication or both. In order to effectively shift gears, the clinician needs to pose a number of questions:

1) Is the symptom the patient is describing part of a medical psychiatric syndrome that may improve with medication?
2) What do the symptoms represent psychologically, considering genetic, transferential and free-associative data?
3) What degree of interference or disruption in the patient's life and treatment is created by the symptoms? Greater severity of such disruptions would prompt the clinician to lean toward medication use.
4) Is the symptom responding to psychological intervention or interpretation?
5) Would adding, changing or withholding medication create adverse or beneficial effects on the psychotherapeutic process?
6) What are the countertransference issues that the clinician is experiencing with regard to the symptoms? Is he or she feeling frustrated, despairing, hopeful, disdainful, etc. about the therapeutic process? Could the clinician be reacting to the discomfort of deepening material or more intense affect states?
7) How does the patient feel about a medication addition or change? What does he or she believe it means about the condition and himself or herself as a person? How may the options be presented to or discussed with the patient in order to facilitate participant prescribing?

In summary, medication use becomes a major event in psychodynamic treatments. Combined treatments benefit from appreciating the dialectic relationship between psychodynamic and psychopharmacological frameworks, both in general and in specific instances in individual treatments. Assessing a patient's clinical response to the medication always involves monitoring its physiological effects. It also includes understanding the meanings to the patient and assessing the psychological impact of:

a) taking medication in and of itself,
b) experiencing somatic, emotional and psychological changes produced by the lessening or elimination of target symptoms or the emergence of side effects, and the changing dynamics of the patient's relationships with the analyst and, if present, the psycho-pharmacologist.

Psychoanalysts and psychodynamic therapists must continue expanding their individual awareness and expertise about medication, and psychopharmacologists must expand theirs regarding dynamic approaches to perception, experience and interpersonal relatedness. When is medication helpful and when does it interfere? What technical interventions may ease the shift from psychopharmacological to psychoanalytic roles? By doing so we may continue to develop new clinical and theoretical models of combining such dissimilar treatments toward a shared goal of improved clinical efficacy.
References:


5. Freud S (1914), On narcissism, S.E. 14, p. 78.


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