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Psychodynamic psychopharmacology concept by D. Mintz and B. Belnap – discussion of the discipline in relation to treatment-resistant patients

Sławomir Murawiec

Summary

The process of educating psychiatrists, and psychiatric textbooks, seldom involve information about combined treatment, integrating psychotherapy and pharmacotherapy. They hardly ever include information about the psychological and relational meaning of medication, which is even more striking, in the situation when many patients undergo psychotherapy and pharmacological treatment simultaneously. Another important issue is the integration of psychological knowledge in the process of understanding the effects of pharmacotherapy. This paper discusses the proposal of a new discipline: psychodynamic psychopharmacology, described in detail by D. Mintz and B. Belnap. Their proposal is not merely theoretical. They also put forward real recommendations for cases of psychologically conditioned resistance to pharmacological treatment. The paper also discusses the issue of "a psychotherapist with knowledge of medication", for all those who are psychotherapists but wish to cross over the boundary between psychotherapy and pharmacotherapy.

pharmacotherapy / psychotherapy / integration

INTRODUCTION

The subject of this paper is psychodynamic psychopharmacology, described by D. Mitnz and B. Belnap, with special emphases on problem patients who fail to respond to standard pharmacological treatment. It is a frequently observed clinical situation that patients treated with medication used in psychiatry are responding to the treatment incompletely or inadequately, or long term pharmacotherapy changes their psychological or physical condition. In such cases the most frequent reaction of their doctor is to change the medication, its dose or method of delivery or combining it with new medicine (medicines). The question is, however, in which categories the patient's responses to treatment should be interpreted. Should they always be related to the need to modify medication? Are they the result of biological processes or can their psychological, social and individual life history be traced? It seems that the psychodynamic psychopharmacology proposed by Mintz and Belnap may be an effective tool, which allows for a cognitive approach to these issues.

G.O.Gabbard and J. Kay [2] analyse the disappearance or dying out of the biopsychological model of being a psychiatrist. They think that the most dramatic illustration of this trend is the decline in focus on the integration of pharmacotherapy and psychotherapy in daily clinical practice. They quote data that shows that 55% of all patients are simultaneously treated psychotherapeutically and pharmacologically (this is the USA statistic, which is not necessarily the same as Polish). Gabbard and Kay do notice, however, that the psychiatry textbooks sel-

Sławomir Murawiec: 3rd Psychiatric Department, Institute of Psychiatry and Neurology, Warsaw, Poland; Correspondence address: Sławomir Murawiec, Institute of Psychiatry and Neurology, 9 Sobieskiego Str., 02-957 Warsaw, Poland, e-mail: murawiec@ipin.edu.pl

dom include chapters on combined treatment with the two methods, which obviously does not mean that there is no literature on the subject. One of the authors with significant work in this field is Gabbard [3, 4]. Moreover, in the education process pharmacotherapy and psychosocial psychiatry are separate subjects of study. The authors quoted here [2] ask how the two areas of study can be integrated if they are taught as two entirely separate treatment modalities.

They point to fact that until the 1970s, the two treatment methods i.e. psychotherapy and pharmacotherapy were still regarded to be mutually exclusive (in Poland, this opinion can be heard even today, even though fortunately less and less frequently). More contemporary research reveals that treatment with both methods simultaneously is most effective. For example in schizophrenia, the use of family therapy, based on psychoeducation and antipsychotic treatment, definitely reduces the recurrence of the illness, as compared with the separate use of the two methods [2].

Gabbard and Kay also discuss another fundamental issue, which happens to be the subject of many controversies, namely should the two types of treatment be administered by two different people? They think that such a distinction promotes Cartesian dualism, and introduces arbitrary division of the patient into the "mind", treated by psychotherapy and the "brain", treated by psychiatry. Whereas when both methods of treatment are administered by one person, they add to the acceptance of the integration of the mind and the brain by the psychiatrist and the patient alike. This treatment model, in which one psychiatrist applies both modalities, requires that he or she can think about his or her patient in terms of brain disorder (from the objective point of view) and empathy, directed at the suffering human being. This two-track approach (bimodal relatedness) is often compared to the way physicists think when they have to consider one phenomenon in terms of both waves and particles. [2, 5]

PSYCHODYNAMIC PSYCHOPHARMACOLOGY.

David Mintz and Barri Belnap [1] propose the use of psychodynamic psychopharmacology, a discipline that admits the significance of and moves towards the basic role of meanings and interpersonal factors in pharmacological treatment. It is not in conflict with traditional objective and descriptive pharmacology, but is, rather, aimed at filling in the biological frames of pharmacology with psychodynamic elements, and their mutual complementarity. This leads to a fuller understanding of patients and results in more effective treatment.

The traditional approach of identifying symptoms and diagnosing illness is based on the search for similarities between different patients. This type of approach is accompanied by the foundations of rational psychopharmacology, and is in itself based on well-established evidence-based information. This creates opportunities for formulating essential instructions and recommendations for choosing an optimal treatment, which increases the likelihood of positive therapeutic outcomes. In a complementary way, psychodynamic pharmacotherapy takes into account all that is individual and unique in a patient. This approach can be of particular value in cases where patients are treatment resistant. With such patients, it is useful to consider what makes them and their response to medication different to other, regular cases. This consideration may be based on the patient's individual life history, patterns that occur throughout the patient's life, current developmental needs and the patient's subjectivity. In this way, instead of giving guidance on *what* to prescribe, psychodynamic pharmacotherapy produces information on *how* to prescribe, to enhance treatment outcomes. These issues were also raised in some Polish sources [6].

According to Mintz and Belnap there are certain fundamental positions in psychodynamic pharmacology that allow for avoiding the risk of a situation which could contribute to a patient's resistance to medication. These are:

– thinking in terms of both the mind and the brain; the "scientific" way of thinking about treatment is concrete, stripped of subjectivity but it exclusively fosters biological factors. Mintz and Belnap ask the following question: when a patient returns a few weeks after he or she has been prescribed medication, and reports an improved mood, how often do psychiatrists ask themselves whether it is the

medication that is behind the improvement? Ultimately, we do not know whether it is the medication or the meaning it carries that has in such a situation improved the patient's condition.
- the significance of learning through experience; medication can support treatment through supporting the learning process; patients with depression or schizophrenia, who are treated pharmacologically, can learn better during psychotherapy. Mintz and Belnap think it is the capacity for learning, and not the elimination of symptoms, that may come first in psychodynamic pharmacotherapy.
- paying attention to the patient's authority; in traditional pharmacotherapy there is a tendency to see a patient as a victim of genes or of "chemical imbalance in the brain". In psychodynamic pharmacology a patient who may be struggling against quite substantial biological deficits is perceived in the context of his or her subjectivity, which remains in interaction with the biological background. A patient is also perceived as having internal resources which might be activated for the improvement of health. A patient is not a passive "battleground" between a doctor and the illness but an ally and adversary in the battle. In this viewpoint the formula of the doctor-patient therapeutic alliance and the aims of treatment have to be mutually agreed.

According to Mintz and Belnap, generally accepted therapeutic treatment algorithms concentrate, above all, on the right choice of medication, its dose, the duration of treatment and correct diagnosis. Resistance to medications is sometimes explained, for example, in terms of personality disorders, as it has been confirmed that personality disorders may reduce a patient's response to medication. It is not clear, however, in what way personality disorders contribute to the fact that an antidepressant or any other medicine may prove ineffective. The algorithms created for the needs of treatment in cases of medication resistance disorders bear no relation to the fact that the problem of medication resistance may be conditioned by non-biological factors. They fail to contain information on the possibility that such resistance may be the consequence of the patient's attitude to the experienced symptoms or the patient's relation to the medicine. They do not refer to the fact that medication resistance may happen in cases of patients with personality disorders, whose relationships with external objects are distorted; the relation which may be reflected in their distorted response to medication. According to Mintz and Belnap, the meaning that medicine carries for a patient may deeply influence the effects of the treatment with that specific medicine.

Mintz and Belnap quote numerous evidence in support of their theses:

- metaanalysis of research into the effectiveness of antidepressants indicates that although the treatment with antidepressants is effective, the placebo effect accounts for between 76 to 81% of the total treatment effectiveness.
- according to Beitman's (1994) research on the treatment of anxiety, the most important predictor of the treatment effectiveness was the patient's "readiness to change". The patients who received the placebo and not the active medicine (beznodiazepine), but who had greater motivation to change, had greater reduction in anxiety than those who received the active medication.
- the research on the significance of the therapeutic doctor-patient alliance, carried out by Krupnick et al. (1996), found that the relationship between the patient and the doctor is more significant than the medication itself. Patients who work well with the doctor achieved better results than patients whose relationship with the doctor was poor; even though it was the second group that received an active medication. Greater improvement occurred when the active substance was given at a time of strong therapeutic alliance.

PSYCHODYNAMICALLY CONDITIONED TRATMENT RESISTANCE

Mintz and Belnap [1] divide medication resistance into two categories, i.e. treatment resistance *to* medication and treatment resistance *from* medication.

They think that in patients who do not respond to pharmacological treatment certain conscious or unconscious factors interfere with the expected effects of treatment. This type of situation is often related to the lack of cooperation in treat-

ment. Another group of patients in this category are those who show a strong psychological or physical response to medication. It is experienced and perceived as the appearance of new symptoms, or a worsening of the existing ones, and also as the appearance of the undesirable impact of treatment.

Psychoanalytical knowledge of unconscious motivation points to the fact that patients may often be ambivalent about relinquishing their symptoms, meaning that they may be unprepared for psychological change. For example, as when symptoms are the source of painful experience but they also help to solve or deter the solution of other important problems.

Patients may resist relinquishing symptoms when those symptoms are needed for communications. For example they may express a desperate need for being cared for, which a patient cannot admit consciously. Another situation where the medication may prove ineffective is the configuration in which its effects may undermine important defence mechanisms.

Mintz and Belnap quote the clinical case of a female schizophrenic patient resistant to medication. The patient was for some time able to take care of her son with her parents' help. Sadly, her son died of cancer, following which the patient could only tolerate antipsychotics that were ineffective. When the option of switching her medication into something stronger and more effective was discussed, the patient started expressing strong fears of depression and suicide. The fact that she heard the voice of her dead son and suffered from the delusional conviction that she could reverse his death sustained the illusion that the child was alive. If she stopped being psychotic she would have to be confronted with her loss. She was afraid then that the grief would kill her. She resisted effective treatment because the improved reality testing would mean for her the rejection of psychotic efforts to maintain the feeling that the child was alive and present, which would result in depression and possibly a suicide attempt.

Patients characterized by the presence of disordered object relations may introduce these problems into the psychopharmacotherapeutic relationship. If a person has essentially positive relations with external objects, taking a medicine may stimulate these positive representations, such as oral gratification. In the case of patients predisposed to it, taking medicine may also stimulate essentially negative representations, such as suffering rejection, poisoning, sexual intrusion or other forms of physical or psychological control.

Ciechanowski et al. [7] have published an interesting piece of research illustrating this phenomenon. They applied attachment theory to cooperation problems in the treatment of diabetic patients. It turned out that the style of forming attachment in childhood translated into the relation with the person in charge of treatment, and consequently into the level of glycosylated hemoglobin in diabetic patients.

What can be misleading is that on the surface a patient asks for help. Patients of this type have difficulties with trustful submission to treatment proposed by their doctor, because they subjectively experience treatment as harmful or likely to produce suffering. These kinds of patients question the motives of their doctor, express fears of losing control, are very interested in side effects and scrupulously negotiate the dose and the timing of medication. This indicates that the representations brought by them to the relationship with their doctor are of a negative character.

In some cases, patients try to take control of the treatment by controlling the doctor. They may give false information, inform the doctor about their symptoms in an incomplete or distorted way and show urgent displays of affect. All these actions are designed to coerce the doctor into prescribing the medication in a way that, according to the patient, is under her or his control and not the doctor's.

Patients may take medication in other dosages than those recommended (too high or too low) or change the way they should be taking their medication. This gives them the feeling of control over the treatment.

Another phenomenon that may be at work here is the nocebo effect, which is the inverse of the placebo effect, i.e. the expectation that the medication will cause damage translates into actual damage, such as the appearance of new psychological or somatic symptoms. The "nocebo patients" are known for notoriously interrupting their treatment due to intolerable side effects, or the therapeutic effect may be impossible to

achieve due to the insufficient dose of medication imposed by low tolerance to side effects.

The next type of treatment resistance, distinguished by Mintz and Belnap, is treatment resistance *from* medication. It appears in the relationship with the medication whose impact is neither feared nor resisted by the patient. Such patients usually ask for the medication and feel its impact as beneficial and effective. The doctor may then observe that the symptoms reported by the patient are reduced but the patient's overall condition does not improve. In such cases resistance to treatment may originate in the medication itself or certain meanings ascribed to the medication. An example of this may be a recurrent slight overdose of the medication or taking it only sporadically. In such cases, the potentially therapeutic effect of the medication is reversed and becomes non-therapeutic or anti-therapeutic. For example a patient suffering from anxiety, who does not trust himself or his own capacities to undertake decisions, may postpone taking any developmental steps until the medication solves all his problems. Such a patient usually regresses and puts his autonomy entirely in the hands of his doctor, whom he considers to have the capacities and potential for controlling the patient's feelings.

In such a situation any challenges seem to enhance the feeling of the lack of competence and a rather nasty counteraction enters the stage: the patient looses his sources of support and concentrates on the illness and the treatment, which is a mere substitute for any attempt to work through and solve the problems.

Another example is using medication in order to defer reaching the stage of insights and potential change. It has, for example, been confirmed that people who feel guilty because of their sexuality are more disinhibited after they take a placebo than the patients who have no such problems. In this way, the treatment can allow the patient to deny parts of his or her own psyche as belonging to him- or herself as he or she will defensively blame the medication. So in the patient's subjective evaluation certain behaviour appears "because of the treatment", having nothing to do with him- or herself.

If a patient's defence mechanisms are based on splitting and projective defences, the patient may locate his or her "badness" in an external object. If he or she undertakes the treatment then there is an open or hidden diagnosis of "something is wrong with me". In this way a dysfunctional behaviour can be ascribed to an illness (according to the formula "it's not me it's the illness"). "Badness" is then placed by the patient in "being ill", which allows for the feeling of his or her identity to focus on good parts of himself only. Such a turn of events may bring relief both to the patient and the doctor, but new problems are likely arise after some time. The way the patient functions may deteriorate as he or she is no longer responsible for his or her destructive behaviour. In effect, the patient's social problems may intensify; he or she may feel a stranger to his or her own behaviour and feelings, and finally show resistance to treatment.

Another example is patients who, in their own psyche, substitute relationships with people by medication, as part of their defence mechanism. Such people, who cannot rely on satisfactory relationships with others, may turn to the relationship with their medication to avoid the frustration of looking for relationships with other people. These patients may have an unconscious motivation to remain ill and resist the inclusion of more adequate methods of therapy.

More work about medication as an object of a relation (like another person) has been published by A. Tutter [8]. Tutter thinks that some people experience and treat medication as persons or as objects. The treatment is then experienced as having certain intentionality and actions that cross over the boundaries of being static, and instead belong to the dynamic world of object relations. There are many ways in which the object relation with medication is established. These relations can change, transform and evolve. According to Tutter, medications can be subjective and experienced by the patient as persons. They may, in other words, be used as objects or contain the representations of an object. Tutter points out that she uses the word "object" in the psychoanalytical sense, as referring to a person, usually another person or subject, but also meaning self, other disassociated fragments of self, or partial objects. In this way of understanding the world, Tutter says that sometimes the persons undergoing treatment have thoughts and feelings and also undertake actions in relation to their medication as if med-

icines were persons, aspects of persons or parts of persons. These references to medication are of a specific character, as if medication has properties, character and functions but is also assigned roles that the patient can refer to meaningfully and dynamically. It is to a certain kind of personification of medication that Tutter links the symbolic meaning of medication. A specific meaning of the relation with medication of a schizophrenic female patient has been also described in Polish sources [9].

In all these situations described above the treatment is effective and the patient sees it as beneficial and takes it willingly. The patient's condition, however, either does not change or it deteriorates.

These phenomena have been described in a lot of interesting detail by the first analysts to conduct clinical research into new medication at the beginning of the 1960's. [10]. They noted, for example, that in the clinical test on a new medication, the improvement of symptoms (decrease in anxiety) took place in the majority of tested patients but could not be considered to have therapeutic effect. They merely noted the effect of the impact of the medication as a situation, in which the pharmacological effect of the medication changed something in a patient's overall functioning, or the course of the illness changed from the one observed previously.

PHARMACOLOGICALLY INFORMED PSYCHOANALYST

The issue of knowledge of medication regards not only medical professionals who could potentially get involved in the psychodynamic pharmacotherapy proposed by Mintz and Balnap [1]. Because an increasing proportion of patients take psychotropics these days, this knowledge is becoming more and more necessary for psychotherapists. This does not mean that what follows is that people without medical training should be prescribing pharmacological treatment, but that they should, as far as possible, acquire a solid knowledge of pharmacotherapy. The publications discussed below refer to psychoanalytical treatment, because they have been published by the authors of this clinical orientation, but their remarks can be discussed in the broader context of psychotherapy as a whole.

What would be the aim of having knowledge of pharmacotherapy for professionals with a psychoanalytical orientation? The question, discussed in various sources is also answered in the work of Marcia Kaplan and Sergio Delgado [11]. They propose the introduction of a certain category of professionals i.e. "pharmacologically informed psychoanalysts". They think that this professional category may encourage a new generation of psychiatrists to undertake psychoanalytical training, and also produce advantages for patients, providing them with high quality psychiatric treatment. These professionals would be capable of learning how to use medication appropriately (avoiding simplifications and schematic procedures of treatment algorithms), just as they are able to learn about self-object transference or projective identification from clinical practice. Through acquiring knowledge of the integrative approach to diagnosis and treatment, such professionals would become an example to follow for psychiatry trainees, who perceive psychoanalysis as a phenomenon of marginal relevance.

Kaplan and Delgado notice that, in our time, the diagnostic approach in psychoanalysis and psychiatry is very different. Biological psychiatrists must obtain enough information to match their observations with the list of symptoms belonging to a given diagnostic category. This diagnostic information depends on the relationship with the patient. Psychoanalysts, on the other hand, in their diagnostic process, evaluate the way a person relates, his or her capacity for reflection, character structure, potential for tolerating transference and capacity for development of a therapeutic alliance. The aim of the integrative approach is not to exclude the diagnostic process but to extend and deepen the contact that can lead to an analysis. The use of medical classification categories and pharmacological treatment may or may not come up as a result from this process.

According to Kaplan and Delgado, psychoanalysts who wish to enter the territory of psychiatry have another goal to achieve. They have to find out how to maintain the psychoanalytic approach, while acquiring information leading to psychiatric diagnosis, and introducing psychiat-

ric treatments. How to conceptualize the meaning of symptoms? Do symptoms reflect brain pathology or psychic conflicts? Does one need to define mechanisms to include them in treatment? An analyst who wishes to consider both ways of looking at these issues would have to find his or her own method to produce a balance between empathetic listening and emotional closeness with a patient on the one hand, and an approach from a distance characteristic of treating symptoms as physical brain pathology. For a mature psychoanalyst, acquiring knowledge of medication is a cognitive task. This knowledge can be only added to one's knowledge base. It is a much more difficult task for a trainee to think analytically because most of the teaching done in psychiatry is distinctly under the influence of medical, behavioural and cognitive science [11]. It may often prove difficult to learn two languages, one of which describes the mind while the other refers to the brain, and "switch over" between the two areas of knowledge. For example, in the case of medically educated trainees there may be a tendency to avoid difficulties with transference and countertransference and "switch over" to the "medical approach" when these occur. In other cases there is a need to understand that sometimes the intensification of symptoms requires conversation rather than medication, whereas there are also cases when the conversation and medication have to be administered simultaneously.

The psychoanalysts' own identification as belonging to a professional group is often built on the basis of the model personalities of teachers and supervisors. Some of them never use medication and do not view pharmacological treatment as legitimate part of analytical practice, simply rejecting it. In such cases the trainees fail to learn how to use medication within the analytic setting, and how to balance and reconcile various ways of thinking in real clinical practice.

This type of practice is probably most challenging for psychoanalysts with a medical training. Whereas psychoanalysts with other than psychiatric backgrounds may have extensive knowledge of neurobiology and neuropsychoanalysis, the decision on including pharmacotherapy is made by those they refer their patients to. The cognitive effort to understand the neurobiological and psychoanalytical basis of psychopathology are the same for both groups but it is the group of psychoanalysts with a medical background that have to face the challenge of applying both forms of treatment in their clinical work with individual patients.

This review of the literature on the subject shows that combining psychopharmacotherapy with psychodynamic knowledge is not an easy task. It requires not only cognitive learning of the principles governing both spheres of knowledge, but also integrating them into one's own ways of thinking, so that a certain balance is achieved in choosing the right intervention while listening to the patient. To be able to avoid changing medication or its dosage in cases, which simply require consultation, but also to avoid neglecting clinical situations in which an application or change of medication could bring the required results.

The issues raised by Gabbard and Key [2] are essential in this type of approach. Even in education, both areas of knowledge are treated as distinct and taught separately. Most often, there is simply no teaching about how to combine psychotherapy with pharmacotherapy or how to understand pharmacotherapy psychodynamically. Gabbard's [3,4] writing is amongst the important exceptions here. Other sources of knowledge on this subject matter are dispersed throughout the professional literature. Handbooks often fail to include chapters that treat this subject area on two levels, in order to make the trainees in psychiatry understand and apply the issues discussed above in their clinical practice. This is the case in spite of the fact that the number of medicated patients is on the increase and an increasing number of patients are in psychotherapy.

CONCLUSIONS

1. There is a need to use psychodynamic knowledge in pharmacological treatment, in the group of patients showing treatment resistance;
2. There is a need to include psychodynamic, psychological and social aspects of all the areas essential for treatment effectiveness in the pharmacotherapy handbooks and other publications on the principles of pharmacotherapeutic treatment.

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