What Is Psychodynamic Psychopharmacology?

An Approach to Pharmacological Treatment Resistance

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A review of Medline citations concerning treatment-resistant psychiatric conditions shows a disconcerting trend. Whereas the number of annual citations for all articles increased by 25% over the past two decades, articles citing psychiatric treatment resistance have increased by over 800%, doubling approximately every 5 years (Mintz, 2010). With significant advances in neurobiology and psychopharmacology, we have become increasingly aware of limitations in the standard treatment approaches to most psychiatric illnesses (Mintz, 2002). We propose that one cause of treatment resistance to biological treatments is an approach that neglects the importance of meaning in the patient's symptoms and in treatment.

"Psychodynamic psychopharmacology" is a discipline that explicitly acknowledges and addresses the central role of meaning and interpersonal factors in psychopharmacological treatment. From our point of view psychodynamic psychopharmacology is not in conflict with a traditional ob-
jective-descriptive approach to psychopharmacology. Rather, the dynamic and biological frames of reference actually complement each other and lead to fuller understanding of the patient as well as to enhanced treatment effectiveness.

A conventional symptom- or diagnosis-based treatment approach considers the ways that patients are similar. This kind of approach brings with it an established evidence base and is a foundation of rational psychopharmacological practice, offering critical guidance about what to prescribe to enhance the likelihood of a positive outcome. In a complementary fashion, psychodynamic psychopharmacology considers what is unique to the individual patient. This approach can become especially important for treatment-resistant patients, who do not respond to treatment as expected. For these patients it is useful to understand what makes them different. Part of the "evidence base" for the psychodynamic approach derives from the patient's unique life history, repeating patterns in the patient's life, current developmental needs, and the patient's subjectivity. Rather than telling the psychopharmacologist what to prescribe, the psychodynamic approach to psychopharmacology informs prescribers how to prescribe to enhance treatment outcomes.

MEANING EFFECTS IN PSYCHOPHARMACOLOGY
Widely accepted psychiatric treatment algorithms are concerned primarily with proper medication choice, adequacy of dose and treatment duration, and correct diagnosis. Treatment resistance is sometimes explained by noting the presence of a personality disorder, since comorbid personality disorders have been found to contribute to treatment resistance (Thase, 1996; see also Chapter 1). It is not clear, however, how or why “personality disorders” make antidepressants or other psychotropics ineffective. Algorithms do not generally consider that the problem may relate to nonbiological factors, such as the meaning of the patient’s symptom or the patient’s relationship to medications, nor do they consider that treatment resistance may emerge in the context of personality disorders when people with disordered object relations have corresponding disturbances in relation to their medications. The meanings that medications have for patients can have a profound impact on medication effectiveness.

An emerging body of evidence comparing biological and symbolic effects of medication points to the importance of meaning in pharmacology. A series of meta-analyses (Khan, Warner, & Brown, 2000; Kirsch, Moore,
Scoboria, & Nicholls, 2002; Kirsch & Sapirstein, 1998) of Food and Drug Administration (FDA) databases (which include unpublished negative study results) shows that, though antidepressant medications are effective, the placebo effect accounts for between 76 and 81% of treatment effectiveness. Placebos produce real, clinically significant and objectively measurable improvements in a wide range of medical conditions (Brody, 1977; Moerman & Jonas, 2002), including psychiatric conditions.

The patient’s “readiness to change” is a central factor in pharmacological treatment response. Beitman, Beck, Deuser, Carter, Davidson, and Maddock (1994) found in a placebo-controlled trial that, among patients treated for anxiety, those who were highly motivated to change and received a benzodiazepine had the most robust response. However, patients who were highly motivated to change and received a placebo had a greater reduction in anxiety than patients receiving the active drug, but who were less ready to change. Readiness to change (Prochaska & DiClemente, 1983) was found to be the single most powerful determinant of treatment effectiveness, even more potent than drug condition (i.e., active vs. placebo).

Similarly, the doctor-patient alliance seems to be more important for pharmacological treatment outcome than medication. A large, multicenter National Institute of Mental Health (NIMH) supported study (Krupnick, Sotsky, Simmens, Moyer, Elkin, et al., 1996) found that in pharmacological treatment, patients had the greatest reduction in symptoms when a strong alliance was paired with active drug. However, patients receiving a placebo who had a good alliance with their doctor had a greater reduction in symptoms than patients with a poor therapeutic alliance who received an active drug. Taken together, these studies support a basic premise of psychodynamic psychopharmacology, suggesting that symbolic aspects of medications are at least as potent as the “biologically active” ingredients and should not be neglected in the care of treatment-resistant patients.

**WHAT MAKES A PATIENT TREATMENT RESISTANT?**

There are as many different kinds of treatment resistance as there are treatment-resistant patients. Nevertheless, it may still be useful to consider resistance to treatment to fall into broad psychopharmacological categories. Writers on the subject have suggested dynamic approaches to pharmacological treatment resistance based on character structure (Forrest, 2004; Marcus, 1990). For the purposes of this chapter, however, we
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divide treatment-resistant patients into two broad categories—those who are treatment resistant to medications and those who are treatment resistant from medications—and look within categories to consider dynamics that interfere with pharmacological effectiveness.

**Treatment Resistance to Medications**

Patients who are resistant to medications have conscious or unconscious factors that interfere with the desired effect of the medications. Often, resistance in this category takes the form of nonadherence to treatment, but it also includes the group of patients that develops adverse psychological and/or physical responses to medications that are experienced as new or worsening symptoms and/or side effects to medication. This is in contrast with patients who are resistant from medications. These patients are eager to receive the medication or some benefit that they ascribe to it. Here the pills may relieve symptoms but do not contribute to an improvement in the patient's quality of life.

It is not difficult to understand why a patient with manic euphoria might resist getting better, but what of a depressed patient who is nonadherent to prescribed medications? If this patient is not simply lazy or irresponsible, what sense does this behavior make? The fundamental psychoanalytic notion of unconscious motivation suggests that patients are often ambivalent about relinquishing their symptoms, albeit generally unconsciously. This concept helps us understand why such patients may not be ready to change. Although patients' symptoms may create painful difficulties for them, at the same time those symptoms may solve other problems. An adolescent who is worried about whether or not he can live up to his parents' expectations and who feels that the only way to be loved and recognized by them is try to be who they think he is, is in the type of dilemma that "illness" temporarily cures. While he remains sick, there is a moratorium on the need to satisfy his parents' expectations. He and his family may make an implicit deal not to judge him as a "failure" until the illness has passed. Even when there is a serious biologically determined illness, patients may be able to derive some benefit from their symptoms, at least at some point in the illness. Other patients may find that, paradoxically, they are far more potent when ill than they ever were when they were well. When illness partially ameliorates deep feelings of powerlessness, patients are understandably ambivalent about relinquishing their symptoms.
Remember that symptoms are not only problems—they are also solutions.

Patients may be reluctant to relinquish symptoms when those symptoms are needed to communicate something important that cannot be said to, or heard by, important others in the patient’s life—for example, expressing a desperate longing for care that the patient cannot consciously bear to acknowledge. When patients find ways to put these encoded communications into words, they may become able to let treatments, including pharmacological treatments, work.

Successful pharmacological treatment may be unconsciously resisted because it undercuts important intrapsychic defenses. For example, consider Mrs. A, who sought help at her family’s urging for treatment-refractory schizophrenia. She had previously been able to organize herself enough to competently raise a child with support from her parents. After her son’s death from cancer, she could only tolerate antipsychotics that were ineffective. Invariably, when considering a switch to potentially more effective medications, she became frightened of becoming depressed and killing herself. Her preoccupation with the hallucinated voice of her dead child and delusional conviction that she could bring back the dead revealed the powerful logic behind her treatment resistance. If she became nonpsychotic, then her child was forever lost; she feared that the grief of this loss would kill her. She unconsciously resisted effective treatment because improved reality testing could interfere with restitutive psychotic efforts (Havens, 1968; Nevins, 1977), with the potential to precipitate a grief reaction that could overwhelm her already limited capacities and risk suicidal depression.

Patients who have disordered object relations are likely to bring these problems into the pharmacotherapeutic relationship, and these problems interfere with a straightforward pharmacological response. Though the ingestion of a pill may activate positive object representations, such as the oral gratification of the nursing situation, in some patients with predominantly positive object representations, ingestion of a pill can also activate profoundly negative object representations, including toxic experiences of rejection, of sexual intrusion, or other forms of physical or psychological control by another.

If prescribers do not recognize that patients, despite presenting to
their doctors in a manifestly trusting request for help, are often deeply suspicious of that help, they may be ill prepared to help patients who form disguised negative transferences. When such patients are healthy enough to mobilize a straightforward resistance, they cannot submit trustfully to the doctor's medication because it is experienced as harmful. These patients are often recognizable by recurrent struggles for control that occur around medications. They will question our motives, express fears of loss of control, show particular interest in the side effects of the medications (i.e., our capacity to harm them), or negotiate in excruciating detail the timing and dosages of the pills, raising questions for the prescriber of whether to insist on rational use of medications or tolerate the patient's irrational efforts at control for some time-limited therapeutic purpose.

In situations where the prescriber asserts control, the patient may attempt to gain control of the medications through control of the doctor. The patient no longer tells the doctor the relevant truth, but instead presents a distorted symptom picture coupled with urgent displays of affect that are intended to coerce the doctor into prescribing a medication regimen that the patient feels is within his or her control (Koenigsberg, 1991). The patient may opt to supplant the doctor, receiving the doctor's prescription but taking the medications according to his or her own whim—either too little, too much, or in dosing schedules that are dangerous or ineffective.

In cases where the doctor manages to maintain control of the medication regimen (see Brockman, 1990, for a compelling clinical description of such an encounter), or when the patient is so ill that all he or she can do is submit to the prescriber, the emergence of nocebo phenomena (Hahn, 1997; Mintz, 2002) may occur. The nocebo effect, which is the inverse of the placebo effect, occurs when the expectation of harm is translated into actual harm in the form of new somatic or psychological symptoms. Although any patient may experience a nocebo reaction, it may be especially prevalent in psychiatric populations (Mintz, 2002), whose members commonly experience their position as disadvantaged and unavoidable—factors known to be nocebogenic (Hahn, 1997). Nocebo-prone patients become treatment resistant when medication trials are repeatedly interrupted by intolerable side effects, or therapeutic doses of medications are never achieved as a result of the patient's exquisite sensitivity to side effects.
Be aware of the nocebo effect—a negative placebo effect—in which expectation of harm leads to experience of harm.

For example, Mr. B, a college-age male, entered treatment for depression and anxiety. He complained particularly of chronic insomnia related to nightly panic attacks. Extensive medication trials had been repeatedly unsuccessful or intolerable. He came from at least three generations of irritably obsessive people, but was misattuned to his family, who regarded him as cranky and demanding from infancy, projectively locating the family pathology in the patient. Consequently, he felt that his family was always trying to “hush” him.

Mr. B was begun on a trial of a selective serotonin reuptake inhibitor (SSRI) for depression and panic and soon began to complain of "emotional deadness," a known SSRI side effect. The therapist-prescriber experienced the patient as less overwhelmed and more able to engage productively in self-exploration, but the patient found the experience intolerable and argued that he was too cut off from his emotions to use therapy. He wanted to stop the medication. It became clear that Mr. B feared that his emotionality was intolerable to the doctor, whom he felt wanted to "hush" him, as had his family. He experienced the medication as a rejection. Once this meaning was engaged in the psychotherapy, they were able to negotiate a more genuine alliance.

**Treatment Resistance from Medication**

Patients may also develop treatment resistance in relation to medications that they neither fear nor resist. These patients ask for medications and experience them as valuable and effective. The prescriber may observe that the medication produces a reduction in symptoms, but the patient does not get better. In these cases, treatment resistance may derive from the medication or some meaning ascribed to the medication. Acting out with medications, as occurs when a patient makes repeated small overdoses or uses a medication “recreationally,” is one way that potentially beneficial medications are turned toward a countertherapeutic effect. Unfortunately, in most cases where treatment resistance is promoted by medications, the dynamic is not obvious, and the prescribing doctor may become an unwitting participant in the development of resistance, colluding with defensive structures in the patient that act counter to the therapeutic intervention of the psychotherapy.
Medications can, for example, play a role in undermining a patient's ability to trust in and learn from his or her feelings. Emotions have an important role in directing learning and in motivating growth and change in relation to the inevitable disappointments of human relationships. This is one reason they become a central focus of psychotherapy. When "pain" or "bad feelings" are defined as part of a "disease" process, the patient's ability to trust and use emotions as necessary data for evaluating the accuracy of perceptions and for decision making is impaired. When medications signify that a patient has symptoms rather than feelings, meaningful opportunities for self-understanding are lost.

Affect competence is the capacity, developed over time, that enables a person to experience and use emotions as a tool to understand himself and others. From it, a patient creates an internal working model of him- or herself and others as relates to what his or her emotions might mean. Affect competence is a developmental achievement that cannot be taken for granted. The culture of the family of origin teaches attitudes toward emotions that become a template for the patient's interpretation of his or her own feelings and those of others (Tomkins, 1995). An aggressive temperament may be encouraged as a sign of competitiveness and strength in one family, whereas in another, the same temperament is pathologized and treated as dangerous. These templates transmit intergenerational learning about the meaning and use of feelings. At times the templates families offer their children bear the scars of a family trauma (see Chapter 5) that cannot be faced. This may manifest itself, for example, in a family that "only looks at the bright side" in an effort to put a trauma behind them, thus leaving children ill equipped to deal competently with sadness or anger. Psychopharmacological interventions for patients who have learned that feelings are useless or inaccessible may reinforce this notion and further undermine their ability to use feelings productively.

People can lose affect competence when they become reliant on a drug to soothe emotional discomfort. A substance-abusing adolescent may develop the attitude that emotions are to be titrated and tightly controlled. He or she might not learn from dysphoric feelings that offer valuable information about the negative effects of his or her actions. Some people use psychopharmacologists in the same way.

Patients who mistrust themselves and their capacities may make decisions that defer development while waiting for medications to solve problems. The patient, thus regressed, can only surrender authority, turning him- or herself over to the doctor, who is presumed to have the ability...
and tools to interpret and control the patient’s feelings. This surrendering risks deepening a sense of incompetence. Entering a vicious cycle, such a patient may lose potentially supportive social roles and may even find that relationships are less likely to support personal growth as the technical language of diagnoses replaces understanding and working through of complex emotional dilemmas. In this way medications may contribute to treatment resistance.

Patients may also use medications in a defensive manner that hinders insight and change. Research into nonpharmacological effects of medications (e.g., the placebo effect) suggests these effects serve defensive functions to manage intrapsychic conflicts (Fisher & Greenberg, 1997). For example, Gibbons and Wright (1981) found that subjects with greater sexual guilt experienced more pronounced sexual disinhibition in response to a placebo than subjects with fewer conflicts about sexuality.

Patients who rely on splitting and projective defenses may manage their “badness” by locating it outside themselves, often in another person. When these patients receive a medication, it may come with an explicit or implicit diagnosis from the doctor that serves as an inexact interpretation (Glover, 1931; Nevins, 1990) signifying, “Your behavior is not you, it is your disease.” This explicit or implicit message supports a defensive disavowal of agency and a split in the patient, who attributes his or her badness to the illness while the remaining goodness resides in him- or herself. When this happens, there is often an initial decrease in his distress. Treaters may be tempted to interpret this response as confirmation of the diagnosis and unwittingly collude with the defense because the decrease in the patient’s excruciating self-hatred is so relieving (for both the patient and doctor). Unfortunately, the final result is often a worsening in the patient’s overall functioning, as the patient no longer feels responsible for destructive behaviors and allows them free rein. The result may be worsening social problems, alienation from self, and treatment resistance.

A similar splitting dynamic can unfold at the interpersonal or family level. The patient and family members may collude in projecting responsibility for negative or conflictual feelings into the illness in order to avoid awareness of family dysfunction. The “badness” of the illness becomes something the family suffers from along with the patient. Whereas illness is projected into the patient, hope is projected into the doctor and his or her “cure.” If the doctor colludes with this biologically reductionistic perception, the patient may be hampered in his or her recovery in several ways. First, the patient cannot learn from a family that has disavowed any
relevance of family patterns to the symptom. Second, this perception may support the family's defensive effort to continue to view the patient as the container of disavowed family problems. Medication may interfere with the family's ability to address and work through developmental impasses by locating the problem in the patient and the solution in the doctor.

Another situation in which medications may cause treatment resistance occurs when people are defensively replaced by medications in patients' psychic lives. These patients, who have often come to experience human relationships as unreliable, may turn to medications to avoid the risk of frustration when seeking comfort from people. In some cases a medication becomes a fetish, more important to these patients than the health it was supposed to generate. These patients may be unconsciously motivated to stay ill to secure certain medications and resist efforts to switch to more appropriate medications.

Patients may use medications to avoid appropriate affect and healthy developmental steps. For example, Mr. C requests treatment of depression and attention-deficit/hyperactivity disorder (ADHD). He complains of inattention and inability to meet work demands that may endanger his employment. Investigation of his situation reveals that Mr. B is working 16-hour days to meet unrealistic job demands. He hopes that a stimulant will allow him to function normally under these extreme circumstances. He cannot admit that the demands of the job may be too much. If the psychopharmacologist colludes with the patient's wish to use medications to erase normal and healthy limits, his depression is unlikely to remit, no matter what medications are used.

Patients' efforts to master past trauma or important developmental failures may lead to a compulsion to repeat the scenario of past failures. This compulsion becomes especially complicated in enactments (see Chapter 2), when an aspect of the treater's life history resonates with and is "hooked" by an aspect of the patient's life history. The requirement to act (prescribe), often under time pressure and with limited information about the patient's dynamics, provides fertile ground for enactments by prescribers.

Consider Mr. D, a patient who experienced repeated early failures in caregiving. He manages feelings about these failures and attempts to preempt future disappointments by ragefully devaluing caregivers. Mr. D's focus on his doctor's failures bolsters a defensive "sour grapes" position or provides vengeful pleasure from exposing the caregiver's inadequacy. The
psychopharmacologist, who sought medical training out of a personal need to feel helpful related to a childhood family role as everyone's helper, experiences feelings of inadequacy with this patient, which he counters by more zealous and aggressive prescribing, leading to an ever more complicated but ineffective medication regimen. The patient, covertly motivated to experience caregivers as failures, does not tell the prescriber about worsening side effects. In this enactment the patient's negative transference expectation is actualized as, ultimately, medications produce more harm than good. Until the prescriber appreciates that the patient may have perverse motivations for treatment (either consciously or unconsciously) and understands his own countertransference to the patient, enactments of this sort can be difficult to detect, formulate, and engage interpretively in the treatment.

This case also suggests a source of treatment resistance other than treatment resistance to or from medications, namely, treatment resistance originating from the prescriber's countertransference. Sometimes it is not the patient who is treatment resistant, but the treatment itself. When the patient's dynamics intersect in particular ways with the prescriber's vulnerability or needs, prescribers may be led to prescribe irrationally. The resulting irrational regimens may not work because they address the prescriber's unconscious needs more than the treatment needs of the patient.

PHILOSOPHICAL UNDERPINNINGS OF PSYCHODYNAMIC PSYCHOPHARMACOLOGY
A psychopharmacologist practicing a biological approach to mental illness tends to make fundamentally different assumptions about the patient, the doctor–patient relationship, and the purpose of treatment than does a psychiatrist who practices with a prominent psychodynamic approach (Roose & Johannet, 1998; Sandberg, 1998). We believe there are several fundamental philosophical positions in psychodynamic psychopharmacology that can help the doctor and patient avoid falling into positions that promote treatment resistance. These positions are (1) the importance of mind–body integration, (2) the value of learning from experience, and (3) the centrality of patient authority.

Though we know that mind and brain are interconnected (Kandel, 1999), with meaning, learning, and experience affecting the physiology of the brain, and physical changes in the brain structuring possibilities of experience, it can be difficult to hold a complex model of mind that avoids
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a mind–body split. Such a split is embedded deep within our worldview, both historically (Goodman, 1991) and also in the context of a contemporary culture in which we have “lost our mind,” with an increasing tendency to see problems in living as problems of biology. The “scientific” way of thinking about medications is concrete (Gutheil, 1982), stripped of subjectivity (Docherty, Marder, van Kammen, & Siris, 1977), and insidiously fosters biological reductionism in our thinking. When a patient receives a new prescription, then returns a week or two later reporting improved mood, how often does the prescriber doubt that the medication is the reason? Ultimately, however, we do not know if a medication or its meaning is what is healing our patient.

Patients may also promote a mind–body split to serve their own needs. This stance may, in turn, influence the thinking of psychiatric caregivers, particularly if the patient defensively (albeit unconsciously) presents his or her symptoms or side effects in the form of an argument for a predominantly biological or psychodynamic etiology. A psychodynamic psychopharmacologist recognizes these sources of bias and works to understand how symptoms are manifestations of both meaning and biology.

For example, Mr. E, a middle-age man with a panic disorder comorbid with a personality disorder and a history of suicide attempts, sought treatment for unremitting depression. Mr. E was in a split treatment, with psychotherapy from one provider and psychopharmacology from another, and he was requiring larger, but ineffective, doses of anxiolytics. He was unaware of any reason for his anxiety. Ultimately the psychopharmacologist informed the patient that he would prescribe no more anxiolytics, instructing the patient to call when having a panic attack so that they might meet and try to understand what precisely the medication was meant to treat. In the urgently scheduled meeting with the prescriber that followed at the time of the next panic attack, it became apparent that the patient felt angry at his therapist and was planning suicide. The thought of dying, however, made him extremely anxious. The patient observed that his anxiety commonly emerged after psychotherapy hours, and that he had not told the therapist of his frustration or anger. The psychopharmacologist reflected back to the patient that he appeared to be requesting anxiolytics so that he could plan suicide without anxiety—which hardly seemed like an appropriate use of medications. The patient agreed to discuss his anger with the therapist. The patient, his therapist, and psychopharmacologist met together to review the dynamic in which the negative transference had been split out, “biologized,” and left to the psychophar-
macologist to detoxify. They agreed that further anxiolytics were not warranted at that time. The patient's "treatment-resistant" anxiety remitted when the negative transference was identified and engaged in the therapy.

In a psychodynamic approach to psychopharmacology, learning is of central value. Medications may support treatments by supporting learning (if defensive uses of medications can be identified and worked through). Medically treating severe depression, anxiety, or psychosis may allow patients to learn better in psychotherapy (Klerman, 1975). However, the optimal level of distress that promotes learning (Yerkes & Dodson, 1908) is not zero. A patient who feels no anxiety, but is too sedated to think, engage in the world, and develop a sense of mastery will not likely recover. Learning, rather than symptom elimination, may take precedence in a psychodynamic approach to pharmacotherapy.

In our approach to psychodynamic psychopharmacology, recognition and respect for patient authority is of fundamental importance. In a biologically reductive approach, the patient tends to be viewed as a victim of genes or of "chemical imbalance." In psychodynamic psychopharmacology the patient, who may be struggling with significantly disordered biology (Cooper, 1985), is understood to have a subjectivity that interacts with the biological substrate and he or she is seen as having internal resources that can be recruited to address problems. The patient is not a passive battleground between the doctor and the disease. Instead, he or she is an important ally, or adversary, and the outcome of pharmacological treatment depends largely upon recognizing and using this stance.

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This position in relation to patient authority has implications for the nature of the therapeutic alliance. Alliance, first of all, is not simply treatment compliance (Gutheil, 1978; see Chapter 8). The goals of the patient may not necessarily be congruent with the a priori goals of the psychopharmacologist. As in a psychotherapeutic contract, the alliance and goals of treatment must be negotiated with the prescriber.

For example, Ms. F, manifestly a high-functioning medical student, presented for treatment of depression and weight loss from somatized gastric pain. Her habitual efforts at becoming what others wanted her to be had left her feeling empty, with almost no sense of agency. One of her
medications promoted weight loss, whereas the alternatives would likely promote weight gain. The pharmacologist, feeling that his first duty was to "do no harm," wanted to change the medication to avoid colluding with further weight loss, but the patient objected. The doctor could have discontinued the medication, but chose first to explore the patient's resistance, with the aim of helping the patient understand her resistance and its connection to broader struggles in her life. It became clear that the patient feared that, if she gained weight, she would not know if this represented her action or the action of the medication. The psychopharmacologist was persuaded not to change the medication, as this served the patient's declared therapeutic goals of differentiating her true self from false self adaptations. The patient was able to incorporate her subsequent weight gain into an experience of her own emerging agency.

One potential countertransference risk is that a greater understanding of the patient's dynamics can be used in ways that diminish patient authority. When an understanding of the patient's vulnerabilities is used primarily to persuade compliance with a particular course of action (e.g., to take medications), this "manipulation" (Bibring, 1954; Niven, 1990) undermines agency. Such manipulation may at times be an unavoidable part of the psychopharmacological intervention, but prescribers working within a psychodynamic frame consider these dynamics and their potential consequences. Manipulation, even if it pushes a patient into making "healthy" choices, can undermine the patient's authority, foster reactive aggression toward the prescriber, and thereby undermine the therapeutic alliance.

TECHNICAL IMPLICATIONS OF PSYCHODYNAMIC PSYCHOPHARMACOLOGY
From the preceding discussion of sources of treatment resistance and the philosophical underpinnings of psychodynamic psychopharmacology, we have derived six basic technical principles for pharmacological practice with treatment-resistant patients. The first, and overarching, principle is to avoid a mind-body split in thinking about patients and their symptoms. Much of this work is internal, done in the mind of the treater, though there are clear technical and framework implications that follow. The second technical principle, following from the first, is that it is essential to know your patient. It is not sufficient to collect a list of symptoms and apply corresponding medications. To adequately care for treatment-resistant patients, one must respect and address the larger meanings for
the patient of medications, illness, and treatment. This leads to the third principle, which is to attend to any ambivalence on the part of the patient about loss of symptoms. Fourth, treaters should be aware that many patients hold, consciously or unconsciously, negative feelings about medications and/or doctors. It may be essential to address negative transferences and resistance to medications in order to promote positive outcomes. Fifth, treaters should also be aware of countertherapeutic uses of medications (resistance from medications). Patients may misuse medications in a myriad of subtle ways, often unconsciously, undercutting either treatment effectiveness or larger developmental aims. Sixth and finally, it is necessary to identify and address the effects of countertransference enactments on prescribing when working with difficult-to-treat patients.

It may be important to note that, while these principles are useful in the treatment of all patients, their application can also be labor intensive and impractical in a busy practice. However, the price of ignoring these principles is high in work with patients who are treatment resistant.

**Six technical principles for pharmacological practice with treatment resistant patients:**

- Avoid a mind–body split.
- Know your patient.
- Attend to the patient’s ambivalence about the loss of symptoms.
- Address negative transferences and resistance to medications.
- Be aware of countertherapeutic uses of medications (resistance *from* medications).
- Identify and contain countertransference enactments involving prescribing.

**Avoid a Mind–Body Split**

The work of avoiding a mind–body split proceeds on two fronts: (1) the development of an integrated treatment frame and (2) subsequent work with the patient to negotiate a realistically complex appreciation of symptoms and how they function for him or her.

In initial meetings with the patient, negotiating an integrated frame may involve clarifying the task of psychodynamic psychopharmacology, which is primarily that of maximizing the patient’s capacity to engage in psychotherapy. When this frame is negotiated with the patient, it may counter his or her hope that symptoms can be eradicated without exam-
ining developmental struggles and making necessary compromises. To the extent that medications serve primarily to support the therapy, resistances to the productive use of medications can be understood by the therapist as resistances to the therapy and as manifestations of the transference, linked in important ways to the patient's underlying struggles. Interpretations aimed at elucidating the dynamics of resistance can then support the work of the psychopharmacologist, just as the psychopharmacology aims to support the psychotherapy.

In split treatments, with a separate therapist and prescriber, communication between providers is essential. Just as the therapeutic alliance is a core factor in producing positive treatment outcomes in psychotherapy (Martin, Garske, & Davis, 2000) and psychopharmacology (Krupnick, Sotsky, Simmons, Moyer, Elkin, et al. 1996), a "triadic alliance" (Kahn, 1991), or a sharing of goals between the patient, the therapist, and the prescriber, may enhance treatment outcomes when there is a split treatment arrangement. A collaborative treatment relationship (Ellison & Harney, 2000), with good interdisciplinary communication between the therapist and prescriber, may be critical in work with treatment-resistant patients, particularly those who have difficulties in integration or who use primitive defense mechanisms such as splitting.

Given that neither the therapist nor the psychopharmacologist will see all the transference implications of medications, communication between treaters may expose ways that the treatment arrangement allows transference to be split off and disguised, as in the case of Mr. E, whose negative transference was expressed as anxiety. When interdisciplinary disagreements are apparent, as when a patient complains about one treater to the other (Gould & Busch, 1998), or when one treater has made an intervention that encroaches on the role of the other (e.g., when a therapist suggests that the patient consider a medication change or when a prescriber interprets to the patient a resistance to medication use), communication between treaters can be especially important.

For patients who see themselves as troubled simply by disordered genes or neurotransmitters, an integrated approach, sometimes even with the therapist and prescriber meeting together with the patient (if in a split treatment), may provide an opportunity to negotiate a treatment agreement that explicitly considers the dimension of meaning in pharmacological care. This process might take the form of describing an evolving understanding of the ways that psychology impacts medication responsiveness (alliance factors, readiness to change, placebo and nocebo re-
sponses), and also a beginning exploration of the underpinnings and implications of a patient's devotion to a reductionistic biological self-understanding. Although it may not be possible to clearly distinguish biologically disordered responses from expectable responses to difficult situations, this conundrum may usefully be left for the patient to struggle with. After all, the process of identifying where one has agency and how feelings are related to choices and context is central to human development and maturation.

Just as it may be useful to question the notion that the entire problem lies in the patient's biology, it may also be helpful to question the notion that all of the healing is in the doctor's medications. This questioning may be especially important when patients have lost affect competence in the face of psychiatric treatments. When patients who have already been failed by countless medical treatments develop magical expectations of cure (sometimes promulgated by previous prescribers), it can be important for the doctor to make a realistic assessment of the likely limitations of medications and to include this information in the patient's informed consent to treatment. This was the case for Mr. C, who sought stimulants in an effort to negate fundamental healthy limitations in his abilities. With Mr. C the recognition of limitations modeled an accommodation to reality that reformulated the question of hope in achievable terms, such as the possibility that he might live with and adapt to the ways that he was ordinarily human, neither perfect nor so flawed that he could not help himself.

**Know Your Patient**

When it comes to the treatment-resistant patient, we concur with the valuable observation attributed to Sir William Osler, the father of modern medicine, that "It is much more important to know what sort of patient has a disease than what sort of disease a patient has." Taking a thorough history can provide a foundation for a psychodynamic approach to the patient's medication use. This history is not simply a detailed history of symptoms and medication trials, but also a developmental history that identifies important life experiences, basic relationship patterns, areas of intrapsychic conflict, and likely transference configurations.

The process of taking a careful developmental history plays an important role in establishing a treatment alliance. When patients are already inclined to experience people as uncaring and narcissistically preoccupied, a prescription given after a brief interview can feel like a rejection (Winer
& Andriukaitis, 1989), providing fertile ground for nocebo reactions and hostile enactments around medication use. Taking a thorough developmental history reminds the patient that the prescriber is interested in him or her as a person, and not just in his or her symptoms, and gives the prescriber ways of understanding and addressing problematic psychosocial factors that may contribute to treatment resistance.

**Attend to the Patient’s Ambivalence about Loss of Symptoms**

The initial history might include tactful questions about what the patient might stand to lose if this symptom were successfully alleviated. It is important to contextualize this question by noting that patients may desperately want to get well, but, as is true for all humans, have a dynamic unconscious and are ambivalent beings. Raising for discussion the question of unconscious ambivalence educates the patient to this possibility, which then becomes included in the work. Mrs. A, whose psychosis protected her from the overwhelming grief over the loss of her child, needed a space to grieve her loss in the context of a secure and reliable therapeutic relationship. She needed to see how her psychosis deepened her loneliness before she was ready to change and accept more effective antipsychotic medications. Highlighting the patient’s ambivalence and exploring the costs of the present solution may motivate him or her to use medications more productively.

**Address Negative Transferences and Resistance to Medications**

Having obtained a thorough history, the prescriber will have some ideas about likely transference paradigms and modes of resistance. Questions concerning the patient’s feelings about medications may, in particular, help predict future problems. Anticipating forms of resistance with the patient (Marcus, 1990) may fortify an alliance with his or her healthier aspects before unconscious resistance emerges. For example, a patient with a repeated history of medication noncompliance and deep conflicts about dependency might be alerted to the fact that emerging fears of dependency on medications should be brought to the prescriber’s and/or therapist’s attention promptly so that they might be addressed rather than acted out through medication noncompliance.

The information gleaned from the developmental history provides an interpretive context so that transference assumptions that have promoted treatment resistance can be brought to consciousness. The patient’s authority may then be mobilized to support rather than hinder treatment
effectiveness. This was the case with Mr. B, who felt that effective medications were a rejection and a sign of his doctor's intolerance of his emotionality. The therapist was able usefully to interpret the patient's concern about medications as a concern that the psychopharmacologist was using medication to "hush" him, as had been his experience in his family of origin. Acknowledging that this expectation might be contributing to side effects of numbness and neurasthenia, the patient agreed to continue the medication. The side effects, which turned out to be a nocebo response, resolved quickly, and Mr. B became panic free and able to sleep for the first time in his adult life.

**Attend to Countertherapeutic Uses of Medications (Resistance from Medications)**

Countertherapeutic uses of medications may be addressed interpretively, as in the case of Mr. E, who was using anxiolytics to avoid the anxiety associated with planning his suicide. In this case making the source of the anxiety conscious was sufficient to motivate the patient to make changes that led to a resolution of his treatment-resistant anxiety. In other cases, such as Mr. D, who used medications to manage feelings and exact revenge on caregivers, the countertherapeutic use of the medication proved too gratifying for him to give up. In these cases, the prescriber need not feel compelled to collude with a patient's demand for a medication that the doctor cannot, in good conscience, prescribe. In these cases, the pharmacologist may negotiate the discontinuation of the medication, or, if the countertherapeutic use of the medication is dangerous or entrenched enough, may make the discontinuation of the medication a condition of continuing pharmacological treatment. This approach also holds true when medications have fetishistic qualities. It may be necessary for the psychopharmacologist to negotiate the discontinuation of the medications so that the patient can learn about their pathological uses and recover some personal authority (Swoiskin, 2001). However, one must also be aware that these patients may be prepared to leave treatment to protect access to their chosen drug.

**Identify and Contain Countertransference Enactments Involving Prescribing**

The treatment of characterologically disturbed patients often includes a goal of containing impulsive action, but not necessarily only the impulsivity of the patient. When patients struggle with overwhelming dysphoric
affects, they often elicit corresponding affects in their prescribers. If the doctor misses the point that these feelings communicate something about the patient’s inner life and must be contained and translated into words, an important opportunity for empathy, alliance building, and deepening the work is missed—and the doctor is left anxious and predisposed to action. If the doctor prescribes from this countertransferential state, he risks failing to address the patient’s symptoms, given that the intervention is aimed more at addressing the doctor’s own distress. The patient, sensitive to the doctor’s needs, may respond to the medication with a masochistic surrender that impairs the emergence of his or her own authority, or if his or her resistance is sparked, power struggles may ensue.

Monitoring for and using countertransference beneficially remains a significant aspect of work with treatment-resistant patients for both therapist and prescriber. As was the case for Mr. B, who wanted to stop a medication that was unconsciously experienced as a rejection, the patient’s request for a change in medications should alert the doctor to consider transference aspects of the request (Busch & Auchincloss, 1995). Similarly, when the doctor contemplates making a change in treatment, he or she might usefully wonder if his or her motivation stems from countertransference.

The issue of countertransference highlights the importance of consultation with colleagues in work with treatment-resistant patients. These patients often cannot be treated in isolation because they push us to the limits of our pharmacological knowledge and our therapeutic and relational creativity. Treatment-resistant patients often push us to emotional limits as well, leading to countertransference-based prescribing. Colleagues can hold the standards of rational prescribing in mind, at a distance from the transference–countertransference tangle, allowing them to function as a valuable “Third” (see Chapter 6), and helping the prescriber avoid becoming lost in the intense feelings evoked in the doctor–patient dyad.

**CONCLUSION**

Psychodynamic psychopharmacology is a way of approaching the task of prescribing that is distinct from, but complementary with, a conventional approach to prescribing, which relies primarily on population-based studies for guidance. A straightforward, “scientific” approach to prescription establishes a “rational” basis for treatment choice, but runs the risk of neglecting the unique impact of the patient’s subjectivity, failing to attend
to the patient's authority, and missing the importance of relationships and of meaning to cure. Given evidence for the importance of these factors in treatment effectiveness, treatments that neglect these factors may inadvertently foster treatment resistance. Psychodynamic psychopharmacology offers a potential antidote to those forms of treatment resistance that may have more to do with subjective factors than with biology.

Despite cultural and psychodynamic influences that promote a mind-body split in our thinking, psychiatric caregivers must remain open to considering the myriad of possible sources of pharmacological treatment resistance, including those of psychosocial origin. The psychodynamic psychopharmacologist appreciates that treatment resistance emerging from the level of meaning is likely to be addressed successfully only at that level. To address such treatment resistance, in split as well as in combined treatments, therapists and psychopharmacologists are wise to attend to the patient's history and dynamics. By practicing a psychodynamic approach to psychopharmacology the doctor is positioned to comprehend and address reasons why a patient may be ambivalent about the loss of symptoms, may react to medications as instruments of harm, or may turn potentially useful medications to countertherapeutic ends. The perspective of psychodynamic psychopharmacology is that patients are not simply victims of biology, but also exercise agency through the way they and their treaters approach their illness. This stance creates the possibility for a deeper alliance in which patients can claim authority for their treatment, and within which the doctor can work with patients to help effect lasting changes in a manner and at a pace that respect patients' unique developmental needs and the significance of their conflicts.

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