PSYCHODYNAMICS OF PSYCHOPHARMCOLOGY*

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WHY THE ASTERISK?

- * THIS LECTURE DRAWS HEAVILY FROM AN APA PRESENTATION OF THE SAME NAME BY BRUCE GAINSLEY, MD, AND ELENA ORTIZ, MD, AND FROM PRESENTATIONS AND WRITINGS BY DAVID MINTZ, MD.

THE PRACTICE OF PSYCHIATRY OUTSIDE IN "THE REAL WORLD"

- PSYCHIATRISTS ARE GENERALLY RELEGATED TO PROVIDING "MEDICATION MANAGEMENT" ONLY, WHILE ANOTHER CLINICIAN (A NON-PSYCHIATRIST) PROVIDES THE "PSYCHOTHERAPY"
- "MEDICATION MANAGEMENT" APPOINTMENTS ARE SHORT
- INSURANCE COMPANIES HEAVILY INCENTIVIZE PSYCHIATRISTS TO PROVIDE SHORTER APPOINTMENTS AND ALSO ALLOW CODING FOR "MEDICATION MANAGEMENT" AND "PSYCHOTHERAPY" SEPARATELY

THE ATTEMPTED MEDICALIZATION OF PSYCHIATRY HAS NOT BEEN SUCCESSFUL IN CHANGING OUTCOMES

- 1990S: " DECADE OF THE BRAIN" PROCLAMATION FROM THE US CONGRESS AND PRESIDENT GEORGE H.W. BUSH
- 2009: NIMH LAUNCHES THE RESEARCH DOMAIN CRITERIA (RDOC) PROJECT

  I SPENT 13 YEARS AT NIMH REALLY PUSHING ON THE NEUROSCIENCE AND GENETICS OF MENTAL DISORDERS, AND WHEN I LOOK BACK ON THAT I REALIZE THAT WHILE I THINK I SUCCEEDED AT GETTING LOTS OF REALLY COOL PAPERS PUBLISHED BY COOL SCIENTISTS AT FAIRLY LARGE COSTS—I THINK $20 BILLION—I DON'T THINK WE MOVED THE NEEDLE IN REDUCING SUICIDE, REDUCING HOSPITALIZATIONS, IMPROVING RECOVERY FOR THE TENS OF MILLIONS OF PEOPLE WHO HAVE MENTAL ILLNESS.

  –TOM INSEL, FORMER NIMH DIRECTOR, IN 2017
- 2013: IN A REVIEW ARTICLE, 25 OF 26 STUDIES EXAMINING PSYCHOSOCIAL INTERVENTIONS TO IMPROVE ANTIDEPRESSANT ADHERENCE COME FROM THE PRIMARY-CARE LITERATURE (ONLY 1 STUDY FROM ORGANIZED PSYCHIATRY)

THERE IS A ***FALSE*** DICHOTOMY BETWEEN THE "BIOLOGICAL" AND THE "PSYCHOLOGICAL/EMOTIONAL" IN PSYCHIATRY

PSYCHOTHERAPEUTIC SKILLS ARE NEEDED IN EVERY SETTING IN PSYCHIATRY BECAUSE THE SAME PHENOMENA OF PSYCHOTHERAPY (TRANSFERENCE, COUNTERTRANSFERENCE, RESISTANCE, SCHEMA, AUTOMATIC THOUGHTS) APPEAR IN EVERY SETTING.

CASE EXAMPLE

A therapist (non-psychiatrist) colleague asks you to assess a patient for an antidepressant. The therapist explains that the patient is debilitated by their symptoms of depression/anxiety, has not improved despite having more than a year of weekly psychotherapy as monotherapy, and has long expressed an antipathy for psychotropics.

In your intake, the patient explains that they are hesitant about medication because they received explicit and/or implicit messages from their family of origin that they need to "pull themselves up by their bootstraps" and not rely on a medication because doing so makes them "weak." They also worry that they may become "dependent" on medication, and they worry about side effects (including the medication possibly changing their personality).

After taking a thorough history, you conclude that an antidepressant is indicated. In the informed-consent discussion, you explore issues of autonomy, shame and other automatic value judgments, and the patient's relationship to their family. You also provide psycho-education about the usual effects of psychotropics. After this conversation, the patient expresses some hesitation but ultimately decides to take the medication.

Can you cleanly separate this discussion with the patient into the biological vs. the psychodynamic?

- **Remember that effective medication treatment is going to involve communication, exploration, and a treatment relationship with a shared expectation of healing, and all of that falls within a broad definition of psychotherapy**
- **Psychodynamic practice isn't just about a style of psychotherapy but it is fundamentally a way of thinking about people that includes interest in the unconscious, in psychological conflict, relationships, and the meanings of lived experience. All of those things are also important in medication management.**

GENERAL PRINCIPLES

- There is no such thing as "just a med check"
- The therapeutic alliance is just as important when you are "only" handling medications as when you are acting as the primary therapist
  - Variability in Treatment outcome can be more related to prescriber effects than to medication effects
  - The most effective prescribers can do more with placebo than can the least effective prescribers with active medication
- Psychotherapy (including psychodynamic psychotherapy) is a biological treatment
- Develop comfort with uncertainty

MEANINGS OF MEDICATION

- The pill itself
  - color
    - Can affect anticipated med effect
    - A review indicated a difference in actual (not just perceived) effect based on colors but results were not always statistically significant
  - Cost (brand vs. generic)
    - 2008 study: A "more expensive" (placebo) pill was rated more effective for pain relief than a "cheaper" placebo pill
    - Patients may perceive that brand-name (and more expensive) medications are more effective and/or have fewer side effects than do generic medications (with the caveat there can be an issue of "actual" chemical sensitivity)

MEANINGS OF MEDICATION

- Meaning to the patient
  - Mind control
  - Distress at the idea of having a chronic illness
  - Patients may miss or value psychiatric symptoms (and may have to re-define their self concept, if medication treatment is effective)
  - Patient have "failed" psychotherapy
  - It's a "biological" problem (which be relieving to the patient)
  - Blow to the ego
  - a gift from the provider

WHAT PATIENT FACTORS AFFECT MEDICATION TREATMENT OUTCOME?

- Neuroticism (characterological tendency toward worry and dysphoria)
- Defensive style
- Locus of control (expectation of whether control and rewards lie within oneself or are external)
- Autonomy
- Sociotropy (an orientation toward others for assistance and focus on pleasing others so as to secure interpersonal attachments)
- Social disadvantage
- Acquiescence (easily surrendering to the will of others)
- Attachment style
- Expectations of treatment
- Treatment preferences
- Ambivalence about medications
- Secondary gains associated with illness
- Autonomous motivation for treatment
- Readiness to change

MEANINGS OF MEDICATION

- Meaning to the prescriber
  - Failure as a therapist
  - Medications as relief (to the prescriber, as much as the patient)
  - Medications as an enactment (perhaps reflecting provider's feelings about the patient, the treatment, or the prescriber's own abilities)
  - Medications as gratification of needs
  - Shift to a medical model
  - **Prescribing that goes against the prescriber's best judgment (or usual manner of prescribing) may suggest they are acting out unconscious psychological material; consultation is strongly recommended**

GENERAL PRESCRIBING TIPS

- Obtain more details (duration, freq, intensity, pt's level of concern about the symptoms, level of functioning, previous med trials, situational factors)
- Psychoeducation
  - Specifically ask pt about their treatment preferences
  - Specifically ask pt for their thoughts about med use (incl thoughts about previous med trials) and previous providers
  - Frankly discuss potential side effects
  - Discuss estimated duration of trial
  - Make it known that you are available to discuss side effects (including via phone between sessions)
- Respect and encourage pt autonomy to share responsibility and authority in clinical care
- Don't confuse acquiescence with alliance
- "Six-minute psychotherapy":
  - Phrase coined by Michael and enid balint (2 psychoanalysts) in the 1950s to help primary-care physician deal with the psychological problems of their patients
  - Instead of grand psychological insights, the idea was to have a "little bang aim": to search modestly into the limited areas of mutual understanding between the patient and the doctor

TIPS FOR WORKING WITH A PATIENT RELUCTANT TO TRY PSYCHOTROPICS

- Can the patient effectively utilize psychotherapy without meds?
- If clinically appropriate, consider first offering a trial of psychotherapy as monotherapy (which may help strengthen the therapeutic alliance) before again offering meds
- Inform the patient that meds might not be needed in the long term, if appropriate (but also be honest about planned duration of the med trial)

FINAL THOUGHTS

- YOUR GOAL AS THE PSYCHOPHARMACOLOGIST IS TO PROVIDE EVIDENCE-*INFORMED* TREATMENT THAT IS INDIVIDUALIZED TO YOUR PATIENT BASED ON YOUR UNDERSTANDING OF UNDERLYING PSYCHODYNAMIC FACTORS. YOUR GOAL IS NOT TO PROVIDE EVIDENCE-BASED TREATMENT THAT IS ONE-SIZE-FITS-ALL
- ***UNDERSTANDING PSYCHODYNAMIC PRINCIPLES WILL MAKE YOU A MORE EFFECTIVE PSYCHOPHARMACOLOGIST***

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