The Medication Life

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The therapist conducting psychodynamic psychotherapy often recommends medication for the patient, but the medication is frequently treated as separate from the therapy and not worth exploring. By not inviting the patient's and our own feelings about medication into the treatment dialogue, we may solicit the development of split transference, the loss of important unconscious material, and noncompliance. Much like a patient's dream life, the medication life is rich in detail that may be fruitfully used to gain information about the patient's experience, strengthen the alliance, and improve treatment outcome.

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Often in the course of psychodynamic psychotherapy, the therapist is faced with making a decision to recommend medication for the patient. Whether this medication is prescribed by the therapist or another provider, the therapist and patient may find that by deciding on medication they cross an invisible line. Beyond this line the brain is treated by medication, and psychodynamic exploration is checked at the crossing like a burdensome piece of heavy luggage. This seems to be a costly way to travel over the long run, and I would like to propose that we integrate the "medication life" of the patient (which includes the prescriber) as a useful source of unconscious material, much like the patient's dream life. Psychodynamic exploration of the many facets of medication-taking can facilitate discovery of the patient's transference and therapist's countertransference, the developmental history of the patient, and the meanings behind medication side effects, noncompliance, and treatment resistance—ultimately improving the treatment outcome.

THE LURE OF ACTION

Phenomena such as noncompliance, treatment resistance,[1] and the placebo effect suggest that the medication life of our patients is thriving, yet health care providers of all stripes may find themselves allowing medication issues to go underexplored. Pressures to act in the therapy affect us all: they include restrictive man-

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aged care requirements, patients' expectations for rapid relief, and recent court decisions regarding the patient's right to treatment.[2] Gutheil[3] has written about the "delusion of precision" we may harbor regarding our diagnostic efforts, and the "mind–brain barrier" that can pull the psychiatrist-therapist into action by prescribing. The challenge to explore the meaning of medication in our patients' lives is great.

Most people with psychological pain today are treated first with medications given by a primary care physician,[4] and yet nearly half of medical outpatients who begin an antidepressant discontinue treatment within the first month.[5] With the newest generation of psychiatric medications, dangerous side effects and lethality in overdose are at a new low and physicians prescribe more readily than ever. However, primary care professionals are called on to perform many different functions for patients, and they may not have the training or the time to examine the meaning of medication-giving and medication-taking. More and more, psychiatrists' practices are filled with patients who have not responded to this initial treatment and who expect an expertly and quickly delivered prescription.

Psychiatrists may play many different roles with patients: therapist-prescriber, separate psychopharmacologist, or nonmedicating psychotherapist. Psychiatrists in any of these positions may unwittingly use the act of prescribing to shift from a therapy role that is perceived as passive into a more directive, "doctorly" role, countering feelings of helplessness in the room. When treating a patient with severe difficulties, this role change can sneak up on the most seasoned psychodynamic therapist. When medication trials are ineffective, these patients are often labeled "treatment-resistant." They seem to be crying out for a full psychological assessment and an exploration of the meaning of taking medication, yet this step is often skipped in favor of yet another psychopharmacologic intervention.

In the psychopharmacology setting, the patient and therapist commonly convey feelings by speaking in "pharmacologese": bothersome side effects substitute for painful affects and defenses, or the need for refills or "prns" expresses the wish for more from the therapist. The shorter time typically allotted for psychopharmacology visits sends the message that the needs being served by medications do not deserve full exploration. Could an alternate explanation for "treatment resistance" or "noncompliance" be that these patients and their treaters suffer from an incomplete understanding of the idiosyncratic meaning of medication? By silently deferring all medication issues to other treatment team members, who may not be willing or able to explore these with the patient, therapists may find themselves in the midst of a split transference.

SPLIT TRANSFERENCE

The history of psychopharmacology's integration with psychotherapy is replete with entrenched opinions against combined treatment[6,7] despite a sizable literature that supports a combined approach to many disorders.[8–10] Medication prescribing, particularly if it occurs out of the psychotherapy office, is often treated as an action that is somehow separate from the therapy and therefore not subject to full exploration. Many transferential and countertransferential reactions are likely to develop around the medication treatment, and these may contribute to the development of a split transference that often goes unrecognized or unexplored. Therapists who refer a patient for medication evaluation may be doing so in order to expel, squelch, or otherwise avoid intolerable transferential or countertransferential feelings.[11,12] Patients may become enraged at the therapist for recommending medication too soon or too late in the therapy, idealize the psychopharmacologist for having a "magic pill," or hate the prescriber and/or the medication, and complain only to the therapist, if the treatment is ineffective. These are only a few of the many examples of the ways in which important feelings can be split between the two treaters in a therapeutic triangle. Just as colluding with the patient's negative transference against another treater is usually countertherapeutic, so can be the temptation to allow medication issues to fall under the sole purview of the prescribing physician.[13] This delegation of duty can also occur in the other direction, as when the psychopharmacologist defers discussion of all feelings to the psychotherapist, including feelings about medications.

A similar phenomenon can occur even when the prescriber also conducts the psychotherapy. A patient and therapist may unconsciously agree on a deal that ensures certain feelings are to be dealt with by medication and others by therapy. The idea of medication may become a container for the negative transference that the patient feels the therapist cannot bear, or for the hope that is more easily invested in a pill than a person. When considering these powerful possibilities, it is perhaps no surprise that noncompliance with med-

ication and other treatments has been reported to range from 25% to 75%.[14] Mintz (personal communication, February 12, 2001) and colleagues at the Austen Riggs Hospital have examined the impact of the dual prescriber/therapist role versus a separate prescriber and therapist on the medication compliance of inpatients. These investigators retrospectively evaluated compliance by patients who had integrated treatment versus separate treatment and found that patients in an integrated treatment were, on average, 11% to 13% more compliant with their medication regimens.

Regardless of the structure of the treatment team, all treaters interested in helping the patient more fully understand him- or herself (separately from, but in addition to, helping the patient get better) may be surprised by the wealth of information available from inquiring about the medication life.

INVITING THE MEDICATION EXPERIENCE INTO THE TREATMENT DIALOGUE

Much like a patient's sex life, work life, drinking life, or dream life, the medication life may have rich and important meaning and yet may be split off from the treatment dialogue. When we allow ourselves to listen for unconscious meanings, the possibilities for discovery involving medication are boundless. I find it useful to consider the patient's medication life as I do the dream life—using not only manifest content but also transference and countertransference associations to further the inquiry. The patient's reactions to the suggestion of medication may cover a range of possibilities: silent assent, energetic willingness, flat-out refusal, narcissistic injury, grateful relief, and more. The patient's first reaction to the idea of medication, much like first reactions to other suggestions in therapy, are quite telling and may have powerful determinants. These feelings typically arise again and again as the treatment progresses, and have an impact on the manner in which the patient accepts the treatment as a whole and experiences the treatment relationship. Questions about the medications, side effect presentation, request for refills, handling of pills, choice of time when pills are taken, storing of tablets, sharing of medication information with other people, and relationship with the pharmacist provide bountiful detail about our patients. These details highlight the patient's level of ego functioning, ability to connect with others, self-advocacy, and favored defenses. Just as one may gauge the patient's therapeutic progress by using dream material, another measure can be made by assessing the changes (or lack thereof) in the patient's experience of pharmacologic treatment over time.

The therapist's countertransferential feelings about prescribing are often directly related to the patient's level of functioning and organization.[15,16] Understanding who is prescribing (therapist-prescriber versus an outside prescriber), what is prescribed, when the prescription is offered or requested, and why (e.g., a reaction to an event in the therapy or a request from the patient) are all pieces of the therapeutic puzzle. These insights can be helpful in understanding and helping the patient, whether or not medication is ever actually prescribed or taken.

The busy psychopharmacologist or primary care physician may ask, "How can I possibly make time for this kind of history-taking?" Shifting the focus from the time spent during a single visit to the time devoted over the long run of a treatment course may help the physician remember that understanding the patient's medication life is often time-conserving, especially when the patient's feelings interfere with treatment compliance. Often, the patient's medication life lies just beneath the surface of other items we commonly cover during visits, such as treatment history. For instance, a patient with a background of adverse reactions to medications may be saying, in action rather than words, that she can't stand to take another pill. The physician may ask a simple question such as, "How do you really feel about taking this medication, anyway?" to open the door to a more direct discussion. Another small investment in time that can reap great benefits is to contact the patient's other providers during a visit, in the patient's presence. Although this may accomplish only an initial outreach at the moment of the call, it sends the message to the patient that you want to be informed about his entire treatment. The manner in which the patient responds to this effort to contact other treaters can also be a source of useful information. These are only a few examples of methods that, when employed over time, can help reveal the richness of the patient's medication life.

USING THE MEDICATION LIFE TO IMPROVE THE WHOLE TREATMENT

A psychodynamic exploration of medication from both the patient's and therapist's perspectives can provide an

opportunity to gain information about the patient that may otherwise be hidden from view and improve the treatment. This may sound like a simple task, but in practice, a meaningful exploration can be difficult to accomplish. In supervision during residency training, I was frequently advised to set aside time during therapy sessions to discuss the medications, rather than to integrate information gleaned within the psychotherapeutic work. The neutral stance and the action of prescribing may seem to be in opposition until we realize that we take many actions in therapeutic work, such as recommending a family therapist or referring an alcoholic patient to Alcoholics Anonymous meetings. As with those other actions, what seems important is to work toward understanding the meaning of prescribing, to both the therapist and the patient. The therapist's conscious acknowledgment of both internal and external pressures to prescribe, when combined with the use of the patient's reactions to treatment with medication, provide an expanded field for working with the patient. A pursuit of the patient's reactions, free from the agenda of convincing the patient to take medications, sets a precedent for how actions are taken in the therapy. This pursuit also strengthens the alliance by sending the message that the therapist is curious about the patient, and it may improve compliance should medication ultimately be accepted by the patient.[17,18] Additionally, it provides a different kind of information than what might otherwise be available about the patient's level of development. This approach may be used to elicit classical oral/anal/phallic conflicts, data regarding integrity of self, object hunger, and maladaptive defenses of all kinds.

Much of modern psychopharmacologic principle assumes that the person taking the pill is a static substrate of a medication's biochemical action. Perhaps in exploring the therapist's and the patient's feelings about pharmacologic treatment, changes can occur to that substrate to make medication interventions more likely to be successful. This seems especially true for the "treatment-resistant" patient, who has become sensitized to the topic of medication and his or her "failure" to respond. The temptation to the pharmacotherapist to prescribe in this situation is especially strong and may prevent a full exploration. The needs of both patient and therapist are often better served by a pause in the action to allow for a use of the transferential and countertransferential reactions to medication to further understand the patient. The patient may know more than we about why she should not, now or perhaps ever, use the pills. Details such as where one patient chooses to store her medications, or why another fears a specific constellation of side effects, may be clues to deeper meaning in that patient's internal life.

CASE EXAMPLES

Ms. A. is an engaging 23-year-old recovering drug abuser with a history of childhood sexual abuse and a diagnosis of posttraumatic stress disorder and borderline personality features. During our initial psychopharmacology consultation, I inquired about her medication life when I noticed that she carried her medications on her person, in a bottle with a wad of cotton at the top. I heard how deeply mistrustful and hypervigilant this woman had learned to be from her harrowing childhood and subsequent years living on the streets. She reported that in the culture of the homeless, a pill-carrying person is assumed ill, and therefore less able to defend herself from attack or theft. Therefore, the sound of pills rattling in a bottle conveyed dangerous vulnerability to this woman, yet she felt a deep comfort from carrying them on her person and being reminded that relief and care were only a swallow away. She carefully maintained the cotton padding in her pill bottle to avoid giving herself away.

Ms. A. developed a positive working alliance with her therapist and remained on a stable course of nefazodone for her anxiety symptoms. Six months after the beginning of treatment, Ms. A.'s therapist announced his plans to discontinue work at the clinic. Almost immediately upon hearing this news, Ms. A. began repetitively taking bottles full of prescription and over-the-counter medications, in parasuicidal gestures, and calmly informing a clinician almost immediately afterward. This maneuver, usually performed just before or after a session, infuriated her treaters to the boiling point; we all wished to fire her as a patient. The complex meaning of her medications became a crucial therapeutic point as Ms. A. drew the team into her experience: caring relationships eventually ended with either abusive neglect or violent rejection.

As her psychopharmacologist, I felt angry and helpless. The very medications I prescribed were simultaneously comforting to her and were being transformed into a weapon the patient used to hurt herself and her treatment relationships. We were in a bind, as I felt that to withhold the medications risked repeating the pattern of neglect in her life. If I continued to prescribe the medications, we would all feel abused by her swallowing them by the bottleful and would risk rejecting her.

We came to understand that Ms. A. desperately wished to rid herself of her dependency on the treatment team after the pain of losing her therapist, and yet she could not bring herself to leave the treatment on her own. By ingesting the contents of each bottle, she rejected and incorporated her treaters at the same time. Had the team enacted its wish to evict her from treatment, Ms. A. would have been lost and

her deepest fears of rejection confirmed. Instead, we discovered a way to use the understanding that the patient was actually trying her best to avoid neglect and abuse at the hands of those whom she had trusted. This information served to soothe the treatment team, allowing us to remain a safe and therapeutic container for this woman's powerful affects and actions. Over time, the treatment team's calm was conveyed to the patient, who was then able, a month later, to stop acting out her painful feelings with the medications.

Mr. Z. is a 42-year-old man with recurrent major depressive disorder, the unemployed son of a mother whose success in the working world kept her busy and often away from the family throughout the patient's childhood. As his therapist was referring him to me for medication treatment, he warned me of Mr. Z.'s intense resistance to taking medication. His stance was based on fears that any medication would make him intolerably, irrevocably nauseated. The patient's previous medication trials were brief, limited by his experience of unacceptable side effects.

Extensive exploration by his therapist revealed Mr. Z.'s formative experiences with being ill in his family, particularly how his occasional childhood vomiting was so repulsive to his mother as to warrant isolation and rejection for days thereafter. Mr. Z. felt this rejection by his mother to mean that he himself was full of badness and therefore unlovable. His previous experiences with taking medication had often led to nausea and the return of feeling himself to be overwhelmingly bad. He could not tolerate this state and usually stopped the medication before an adequate trial had been attained. He was loath to report the nausea to his previous prescribers for fear that he would be viewed as a disgusting complainer. In this way, he unwittingly reenacted his childhood experience of distance between himself and his caretaker (mother) when he was most in need of reassurance and care.

This crucial historical information enabled me to provide a more comprehensive treatment plan, which included frequent communication and close monitoring of side effects to counter the patient's fantasy that I would dismiss these concerns and, like his mother, withdraw from him. This plan reassured the patient, enabling him to tolerate a therapeutic trial of much-needed antidepressant medication despite episodic nausea. He became less depressed and anxious, and after 6 months of treatment he entered graduate school. He continues to struggle with the meaning of medication in his life, but now with words rather than the somatic symptoms that had interfered with treatments in the past.

These cases illustrate a mutual learning, which provides a rich avenue for exploration of the meaning of taking a pill. Without such dynamic understanding, these treatments were heading toward becoming a repetition of past disappointments for both patients.

SUMMARY

The many details surrounding the act of prescribing medication may be fruitfully used to gain information about the patient's experience. Medications have been unnecessarily imbued with "otherness" and often are silently delegated to other treaters to explore. Not surprisingly, this commonly results in a neglect of the medication life in the treatment as a whole. I suggest that a rich source of data is lost when treaters take this approach. As seen in the case vignettes, a lack of understanding of the medication life can lead to dangerous actions, or undertreatment, psychotherapeutically or psychopharmacologically. Exploration of the patient's thoughts and feelings about medication can provide beneficial therapeutic avenues and improved compliance, especially in this time of increased managed care expectations for quick, effective, medicated treatment. Whether acting as therapist-prescriber, therapist, or prescriber without a specified role as psychotherapist, mental health practitioners and our patients could all benefit from a curious exploration of the medication life.

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