

# Psychodynamic factors in psychotropic prescribing



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Being aware of these factors can enhance the therapeutic alliance and improve outcomes

**M**edical noncompliance and patient resistance to treatment are frequent problems in medical practice. According to an older report by the US Office of Inspector General, approximately 125,000 people die each year in the United States because they do not take their medication properly.<sup>1</sup> The World Health Organization reported that 10% to 25% of hospital and nursing home admissions are a result of patient noncompliance.<sup>2</sup> In addition, approximately 50% of prescriptions filled for chronic diseases in developed nations are not taken correctly, and up to 40% of patients do not adhere to their treatment regimens.<sup>2</sup> Among psychiatric patients, noncompliance with medications and other treatments ranges from 25% to 75%.<sup>3</sup>

In recent years, combining pharmacotherapy with psychodynamic psychotherapy has become a fairly common form of psychiatric practice. A main reason for combining these treatments is that a patient with severe psychiatric symptoms may be unable to engage in self-reflective insightful therapy until those symptoms are substantially relieved with pharmacotherapy. The efficacy of combined pharmacotherapy/psychotherapy may also be more than additive and result in a therapeutic alliance that is greater than the sum of the 2 individual treatments.<sup>4</sup> Establishing a therapeutic alliance is critical to successful treatment, but this alliance can be distorted by the needs and expectations of both the patient and the clinician.

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A psychodynamic understanding of the patient and the therapeutic alliance can facilitate combined treatment in several ways. It can lead to better communication, which in turn can lead to a realistic discussion of a patient's fears and worries about any medications they have been prescribed. A dynamically aware clinician may better understand what the symptoms mean to the patient. Such clinicians will not only be able to explain the value of a medication, its target symptoms, and the rationale for taking it, but will also be able to discuss the psychological significance of the medication, along with its medical and biological significance.<sup>5</sup>

This article briefly reviews the therapeutic alliance and the influence of transference (the emotional reactions of the patient towards the clinician),<sup>6</sup> countertransference (the emotional reactions of the clinician towards the patient),<sup>6</sup> and patient resistance/nonadherence to treatment on the failure or success of pharmacotherapy. We provide case examples to illustrate how these psychodynamic factors can be at play in prescribing.

### The therapeutic alliance

The therapeutic alliance is a rational agreement or contract between a patient and the clinician; it is a cornerstone of treatment in medicine.<sup>6</sup> Its basic premise is that the patient's rational expectation that their physician is appropriately qualified, will perform a suitable evaluation, and will prescribe relevant treatment is matched by the physician's expectation that the patient will do their best to comply with treatment recommendations. For this to succeed, the contract needs to be straightforward, and there needs to be no covert agenda. A covert agenda may be in the form of unrealistic expectations and wishes rooted in insecure experiences in childhood by either party. A patient under stress may react to the physician with mistrust, excessive demands, and noncompliance. A physician under stress may react to a patient by becoming authoritative or indecisive, or by overmedicating or underprescribing.

### Transference

Transference is a phenomenon whereby a patient's feelings and attitudes are unconsciously transferred from a person or situation in the past to the clinician or treatment in the present.<sup>6</sup> For example, a patient who is scared of a serious illness may adopt a helpless, childlike role and project an omnipotent, parentlike quality on the clinician (positive transference) that may be unrealistic. Positive transference may underlie a placebo response to medication in which a patient's response is too quick or too complete, and it may be a way of unconsciously pleasing an authoritative parent figure from childhood. On the other hand, a patient may unconsciously view their physician as a controlling parent (negative transference) and react angrily or rebelliously. A patient's flirtatious behavior toward their physician may be a form of transference from unresolved sexual trauma during childhood. However, not all patient reactions should be considered transference; a patient may be appropriately thankful and deferential, or irritated and questioning, depending on the clinician's demeanor and treatment approach.

### Countertransference

Countertransference is the response elicited in the physician by a patient's appearance and behaviors, or by a patient's transference projections.<sup>6</sup> This response can be positive or negative and includes both feelings and associated thoughts related to the physician's past experiences. For example, a physician in the emergency department may get angry with a patient with an alcohol use disorder because of the physician's negative experiences with an alcoholic parent during childhood. On the other hand, a physician raised by a compulsive mother may order unnecessary tests on a demanding older female patient. Or, a clinician raised by a sheltering parent may react to a hapless and dependent patient by spending excessive time with them or providing additional medication samples. However, not all clinician reactions are countertransference. For example, a physician's empathic or stoic demeanor may be an appropriate

### Clinical Point

**Positive transference may underlie a placebo response to a medication**



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emotional response to a patient's diagnosis such as cancer.

### Patient resistance/nonadherence

In 1920, Freud conceptualized the psychodynamic factors in patient resistance to treatment and theorized that many patients were unconsciously reluctant to give up their symptoms or were driven, for transference reasons, to resist the physician.<sup>7</sup> This same concept may underlie patient resistance to pharmacotherapy. When symptoms constitute an important defense mechanism, patients are likely to resist medication effects until they have developed more mature defenses or more effective ways of coping.<sup>8</sup> Even when patients do not resist symptom relief, they may still resist the physician's choice of treatment due to negative transference. Such patients often negotiate the type of medication, dose, timing of the dose, and start date as a way of trying to "keep control" of a "doctor they don't quite trust."<sup>8</sup> They may manage their own medication regimen by taking more or less than the prescribed dose. This resistance might lead to a "nocebo" effect in which a medication trial fails not because of its ineffectiveness but instead from the unconscious mind influencing the patient's body to resist. Nonadherence to treatment may occur in patients who have attachment difficulties that make it difficult for them to trust anyone as a result of negative childhood experiences.<sup>9</sup> Clinicians need to recognize the dynamics of power struggles, control, and trust. A warm, collaborative and cooperative stance is likely to be more beneficial than an authoritative and detached approach.<sup>10</sup>

The following 3 case examples illustrate how psychodynamic factors such as transference and countertransference can influence the therapeutic alliance, treatment decisions, and the outcomes of pharmacotherapy.

#### CASE 1

Mr. A, age 63, has posttraumatic stress disorder originating from his father's death by a self-inflicted gunshot wound when Mr. A was 19, and later from the symbolic loss of

his mother when she remarried. He reported vivid memories of his father sexually assaulting his mother when he was 6. This fostered a protective nature in him for his mother, as well as for his 3 younger siblings. After his father's suicide, Mr. A had to take on a paternal role for his 3 siblings. He often feels he grew up too quickly, and resents this. He feels his mother betrayed him when she got remarried. Mr. A attempts suicide, is admitted to a local hospital, and then follows up at a university hospital outpatient psychiatry clinic.

At the clinic, Mr. A begins psychodynamic psychotherapy with a female resident physician. They establish a good rapport. Mr. A begins working through his past traumas and looks forward to his therapy sessions. The physician views this as positive transference, perhaps because her personality style and appearance are similar to that of Mr. A's mother. She also often notes a positive countertransference during sessions; Mr. A seemingly reminds her of her father in personality and appearance. Perhaps due to this positive transference/positive countertransference dynamic, Mr. A feels comfortable with having his medication regimen simplified after years of unsuccessful medication trials and a course of electroconvulsive therapy. His regimen soon consists of only a selective serotonin reuptake inhibitor and a glutamate modulator as an adjunct for anxiety. Psychotherapy sessions remain the mainstay of his treatment plan. Mr. A's mood and anxiety improve significantly over a short time.

#### CASE 2

Ms. G, age 24, is admitted to a partial hospitalization program (PHP). Her diagnoses include seasonal affective disorder, anxiety, and attention-deficit/hyperactivity disorder (ADHD); she might have a genetic disposition to bipolar disorder. Ms. G recently had attempted suicide and was discharged from an inpatient unit. She is a middle child and was raised by emotionally and verbally abusive parents in a tumultuous household. Her father rarely kept a job for more than a few months, displayed rage, and lacked empathy. Ms. G feels unloved by her mother and says that her mother is emotionally unstable.

### Clinical Point

**When symptoms serve as a defense mechanism, patients are likely to resist medication effects**



## Psychodynamic factors in prescribing

### Clinical Point

**Nonadherence to treatment may occur in patients with attachment issues that make it difficult for them to trust anyone**

### Related Resources

- Neumann M, Silva N, Opler DJ. ARISE to supportive psychotherapy. *Current Psychiatry*. 2021;20(5):48-49. doi:10.12788/cp.0123
- Mintz D. Psychodynamic psychopharmacology. *Psychiatric Times*. 2011;28(9). <https://www.psychiatrictimes.com/view/psychodynamic-psychopharmacology>

Upon admission to the PHP, Ms. G is quick to question the credentials of every staff member she meets, and suggests the abuse and lack of trust she had experienced during her formative years have made her aggressive and paranoid.

Since her teens, Ms. G had received treatment for ADHD with various stimulant and non-stimulant medications that were prescribed by an outpatient psychiatrist. During her sophomore year of college, she was also prescribed medications for depression and anxiety. Ms. G speaks very highly of and praises the skill of her previous psychiatrist while voicing concerns about having to see new clinicians in the PHP. She had recently seen a therapist who moved out of state after a few sessions. Ms. G has abandonment fears and appears to react with anger toward new clinicians.

A negative transference towards Ms. G's treatment team and the PHP as a whole are evident during the first week. She skips most group therapy sessions and criticizes the clinicians' skills and training as ineffective. When her psychiatrist recommends changes in medication, she initially argues. She eventually agrees to take a new medication but soon reports intolerable adverse effects, which suggests negative transference toward the psychiatrist as an authority figure, and toward the medication as an extension of the psychiatrist. The treatment

team also interprets this as nocebo effect. Ms. G engages in "splitting" by complaining about her psychiatrist to her therapist. The psychiatrist resents having been belittled. Ms. G demands to see a different psychiatrist, and when her demands are not met, she discharges herself from the PHP against medical advice. The treatment team interprets Ms. G's resistance to treatment to have resulted from poor attachment during childhood and subsequent negative transference.

### CASE 3

Ms. U, age 60, is seen at a local mental health center and diagnosed with major depressive disorder, likely resulting from grief and loss from her husband's recent death. She was raised by her single mother and mostly absent father. Ms. U is a homemaker and had been married for more than 30 years. She participates in weekly psychotherapy with a young male psychiatrist, who prescribes an antidepressant. Ms. U is eager to please and makes every effort to be the perfect patient: she is always early for her appointments, takes her medications as prescribed, and frequently expresses her respect and appreciation for her psychiatrist. Within a few weeks, Ms. U's depressive symptoms rapidly improve.

Ms. U is a talented and avid knit and crochet expert. At an appointment soon before Christmas, she gives her psychiatrist a pair of socks she knitted. While the gift is of little monetary value, the psychiatrist interprets this as part of transference, but the intimate nature of the gift makes him uncomfortable. He and Ms. U discuss this at length, which reveals definite transference as Ms. U says the psychiatrist perhaps reminds her of her husband, who also had brown skin. It is also apparent that Ms. U's tendency to please perhaps comes from the lack of having a father

## Bottom Line

Even clinicians who do not provide psychodynamic psychotherapy can use an awareness of psychodynamic factors to improve treatment. Psychodynamic factors such as transference and countertransference can influence the therapeutic alliance, treatment decisions, and patient outcomes. Patients' experiences and difficulties with attachment during childhood should be recognized and addressed as part of pharmacotherapy.

figure, which her husband had fulfilled. The psychiatrist believes that Ms. U's rapid response may be a placebo effect from positive transference. Upon further reflection, the psychiatrist realizes that Ms. U is a motherly figure to him, and that positive countertransference is at play in that he could not turn down the gift and had looked forward to the therapy sessions with her.

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#### Clinical Point

**Clinicians need to recognize the dynamics of power struggles, control, and trust**