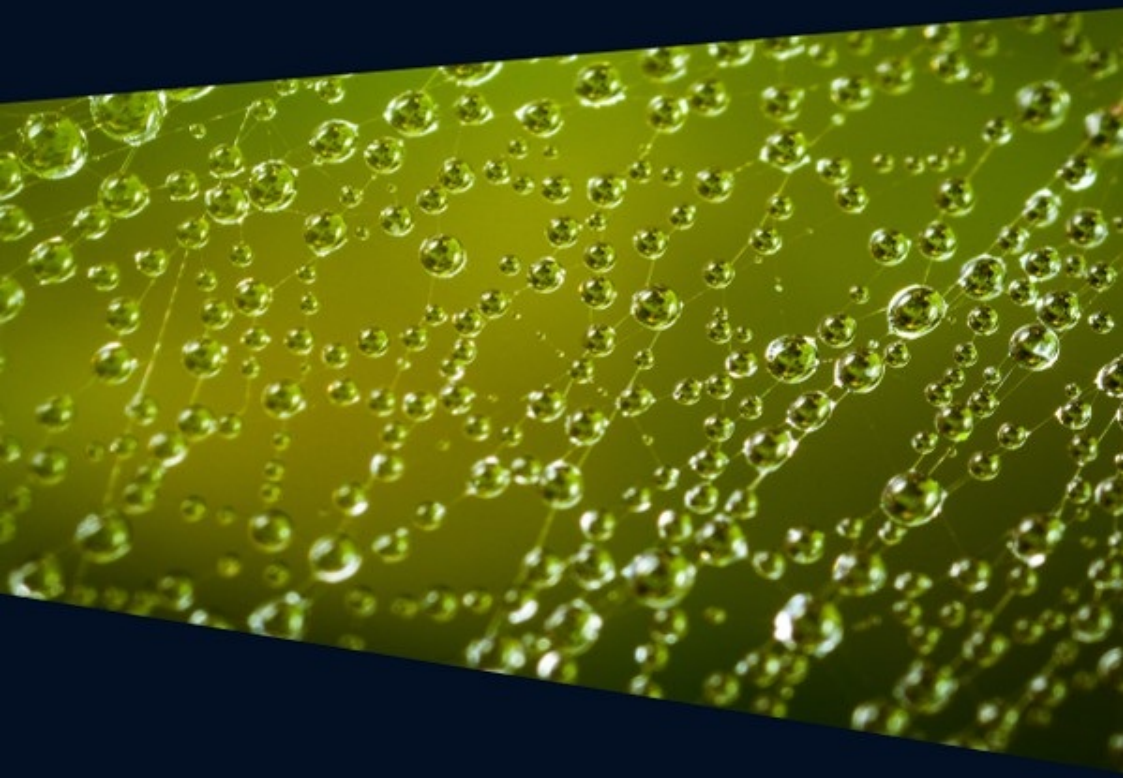
Combined Psychotherapy & Pharmacology



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In discussing combined psychotherapy and psychopharmacology, several basic assumptions will be summarized to lay the groundwork for a discussion of the principles involved.

Psychotherapy and the Doctor-Patient Relationship

The assumption is that the patient is able to participate in psychotherapy and is able to make significant efforts to help himself master those of his problems which at the moment in time are partially or totally unmastered, thus producing symptoms. The patient has to have the attitude that he/she is to work, as an active participant in the process, while the doctor is helping him/her do this, using the therapeutic alliance that exists between doctor and patient for this purpose. This “psychotherapeutic doctor-patient relationship” differs from the “classic doctor-patient relationship.” In the latter, the patient has done his duty when he has presented his body and his problems to the doctor for the physician's ministrations. The doctor in this "classic” doctor-patient relationship does the work, the patient being the passively-active recipient of the physician’s acts.

In combined psychotherapy and pharmacotherapy, it is a basic assumption that the physician has a therapeutic alliance with the patient for dealing with the patient’s problems. The patient discusses with the physician the problems that come to his or her mind. This is true for supportive or relationship psychotherapy in which the doctor is steady, present, friendly but objective, in relating to the patient, who develops a feeling of being cared for and strengthened.

Target Symptom Approach to Pharmacotherapy

A medication is given to obtain the particular effects of the medication (4, 7, 11, 12, 22, 24, 25). With both neuroleptics and antidepressant drugs given in adequate dosage, the patients will show the characteristic "clinical pharmacological profile of the drug concerned" (15). This characteristic pharmacological effect is not "specific" for the therapy of a particular psychiatric disease, even though it reliably produces its typical pharmacological action. This is a complicated way of saying that the characteristic clinical pharmacological action of the drug does not necessarily "cure" the psychiatric illness. This author has published studies (1, 12-18, 20) indicating that the establishment of a neuroleptic effect of an "antidepressant" effect influences different patients in different ways, even though the same characteristic clinical pharmacological profile of the drug is present. Some patients, whose major symptoms are controlled or partially controlled by the drug, can improve remarkably quickly. Some improve initially and explore with their significant entourage whether they are indeed better, since they feel better or are beginning to feel better. If their entourage of significant individuals responds with, "Yes, you have changed," the patient continues to integrate his defences in progression towards relative health (17). In some patients, the typical clinical pharmacological profile of a drug may not control symptoms or signs, which are to the patients *the* significant landmarks proving that they are ill or out of their own control. When this occurs, these patients remain essentially clinically unimproved despite the presence of the pharmacological action of the drug. Other patients begin to improve when the drug controls significant symptoms, but if their significant people signal that they are unchanged, or that they are seen as inadequate, they rapidly relapse despite the continuing effects of the drug.

Both Freyhan (2) and Sarwer-Foner (15) advocated a "Target Symptom" approach to psychopharmacology in which the physiological action of the drug given in adequate dosage is used to control specific symptom complexes. For example, if one wants to stop agitation, to control the amount of energy available

to striated muscle and the locomotive systems for aggressive, or energetic display, to lower the blood pressure, make a patient feel tired, sleepy, and make him feel held down and need to lie in bed, then a straight-chain phenothiazine having all the above mentioned actions would be used. If instead one wants a patient to be ambulatory despite a neuroleptic dampening effect, i.e. dopaminergic blockade, reducing capacity for muscular energetic action and reducing the feeling of wishing to act while permitting the patient to be up and about, then one of the piperazine substituted phenothiazines would be used. Here the patient's energy is reduced, but there is less tendency to produce a significant fall in blood pressure. The patient therefore finds it easier to be up and around even though he feels chemically held down, and under better control in terms of aggression and energy use.

The patient reacts to the physiological effects of a drug, its side effects, and the neuroleptically determined reactions such as akathisia, dyskinetic reactions, parkinsonism, etc. with either feelings of, "Yes, this is unpleasant, but it is good for me and I can take it," or "It is a hostile brutal attack on me, why are you doing this—you're like everyone else and I won't let you do this to me." If he feels in the last described way, the patient can become more disturbed. This latter often produces (in all varieties of patients, not just schizophrenic patients) the psychodynamically determined "paradoxical" drug reaction which we have previously reported (13). We have elsewhere published the psychodynamic principles governing this type of patient in relationship to drugs and established criteria for selection and for contraindications.

One must at this point introduce the problem of countertransference (16). If the doctor does not like, or fears, the patient (and many patients have excellent reality-testing mechanisms in this sense), and does not wish to become involved psychotherapeutically, he can give drugs as an "excellent" excuse to keep distance between himself and the patient. We have seen physicians trigger panic reactions in patients, not because of anything necessarily specific in that patient, but because the patient sensed all too well the deep rejection of himself by the

authoritarian treating figure. This rejection was implied precisely when the physician gave the patient the drug in the first place; therefore, the physiological effects of the drug were interpreted by the patient as a rejecting, hostile, and threatening thing.

Dopaminergic Blockade

It is likely that dopaminergic blockade action by the neuroleptic drugs affects the buildup of the impulse to act at a motor level (9) in the central nervous system by lessening it, and that this is useful in dampening down the energetic tendencies of many schizophrenic patients. However, this is not specifically curative of schizophrenia. It lessens the quantity of action-oriented symptoms in schizophrenic patients, which can have a beneficial effect, once the neuroleptic effect is established, on secondary psychopathological constructs such as the capacity to have hallucinations, delusions, and ideas of reference. The latter actions are, however, secondary phenomena and are not seen in all patients.

Combining Psychotherapy and Chemotherapy

If the above principles are understood, we can then turn to the use of combined psychotherapy and chemotherapy in acute schizophrenic reactions in the hands of the skilled psychiatrist who understands both psychotherapy and pharmacotherapy. In the supportive relationship with an acutely psychotic patient, the doctor would have the basic therapeutic attitude that the patient was potentially capable of pulling himself together and of taking responsibility at some level for his potential improvement even while grossly psychotic. The physician would explain the need for neuroleptic medication after exploring this with the patient. Neuroleptic medication could be given to an involuntary patient, the action of the drug explained, and the patient encouraged to use this action to collaborate with the physician and improve his state.

The drug effect is subjectively perceived by the patient (8, 23). In the midst of an acute psychosis, if the patient sees the doctor as someone with whom he could form a therapeutic alliance, this sets the stage for the patient to begin to test out the doctor's reliability as a potentially trusted person even around crisis intervention in the emergency room or receiving hospital. In other words, this experience can be the beginning of a "bonding" relationship between that patient and that particular physician or other therapeutic staff who participate in helping the patient in acute crisis. As the patient settles down, the fact (because it is then a fact) that the doctor understands enough to give the patient what is needed while encouraging the patient's active collaboration in getting well cements the beginning of the doctor-patient supportive psychotherapeutic relationship.

The patient is then encouraged to discuss the problems in this context, and the doctor does reality-testing psychotherapy with the patient, while the drug is being given. The drug is given with the patient understanding that it will be given for as long as the patient needs it. The length of drug therapy is left as a variable quantity of time, but with a definite implication that when the patient can get along without the drug, the drug will be stopped. By then the patient will have been taught how to use the drug, either with the doctor's help or alone, so that should the patient need further help when things go out of the patient's control, the medicine is available, as well as the doctor's relationship. This is perhaps the trickiest part of the supportive combined psychotherapeutic-pharmacotherapeutic relationship with acutely psychotic patients. Many of these, once they recover, "want no part of anything," including the therapeutic relationship, that reminds them of having been ill (19). The patient must, therefore, be helped to understand the importance of being able to deal with things themselves and handle medicine over a period of time.

In the past, probably the majority of doctors felt that a schizophrenic patient who had had an acute and serious psychotic episode needed ongoing maintenance therapy (i.e. without stop). This author never shared this view for *all* patients, preferring the above-mentioned visualization for many treated in a

personalized therapeutic context. The late complications of maintenance neuroleptic therapies, such as tardive or persistent dyskinesia, have done much to bring the need for time-related and time-controlled drug therapies into focus. As a result, many who previously favored ongoing maintenance therapy have adopted a more favorable consideration of a target symptom, patient-physician, cooperation- oriented approach to the chemotherapy, thus tending to introduce more and more of the psychotherapeutic element. In this regard, some studies of "sociotherapy" and pharmacotherapy (3, 6) have shown that the more than two-year progress of patients on neuroleptics and supportive relationship is better as to quality of life, work performance, etc., than straight drug therapy, and this in a straight, once-a-month social work contact.

Treatment of Schizophrenia

A potent neuroleptic, given in adequate dosage, will present its characteristic pharmacological profile in the patient receiving it. Regardless of what this profile is (and it will vary from drug to drug), the neuroleptic drugs have a beneficial effect in schizophrenia when the following conditions seem to be satisfied:

1. The physiological effects (pharmacologic profile) of a drug permit control of a symptom or symptom complex.

2. This symptom complex must express for this particular patient his inability to face himself and his most feared impulses. Here I refer to those specific impulses which, for this particular patient, represent the core of the inner conflict that he cannot solve for himself without regressing into his schizophrenic illness as his best personal compromise.

3. The control of this symptom or symptom complex must be interpreted by the patient as beneficial for him rather than detrimental to him.

4. The patient considers this in terms of his total constellation of impulses, his defences against them, and his present reality situation. Therefore, the patient who benefits from the characteristic

pharmacological profile of the neuroleptic medication does so because he interprets the action of the drug in controlling certain symptoms or symptom complexes as a “good” thing for him rather than a “bad” thing for him. For the majority of such patients, much of the efficacy of the medication depends on these external variables which help to give its pharmacological profile the value judgment “good” or “bad.” Some of these include the attitude of the doctors, nurses, and orderlies towards both the particular drug and the patient's reaction to receiving it. The unconscious, as well as the conscious, visualization by the patient of what is appropriate to the hospital setting (that is, what is sociologically required of him when under the influence of a drug and therefore is controlled in reference to the standards of behavior in a specific hospital society) may play some role here. Many external factors concerned with interpersonal relations in psychotherapy are vital here.

5. When the above-mentioned symptom complex is controlled by the drug, this lays the foundation for the fundamental process of remitting from a regressed state, that is to say, for ego growth, and the enlarging of neurotic and normal defenses. It is to be emphasized that the patient does not immediately return from a regressed state.

It must be remembered that there are many different types of schizophrenic patients, and there are many approaches to the treatment of patients and to interpersonal dealings with such patients. Not all of these patients need drugs, but in those who do and get better, we feel that the modalities of the treatment are those we are describing.

When a patient with a schizophrenic illness arrives in hospital in an acute phase of his illness, he can be approached from the point of view that you in the hospital are going to help him overcome and master what he is most afraid of in himself and fears in others as stimulating these impulses in him.

Those patients who do well on the drug do so because the drug helps control symptoms expressing the patient’s attempts to cope with problems such as intolerable aggression, perverse sexuality, and feelings of total inadequacy producing tremendous frustration, rage and anger. When the physiological

effects of the drug help the patient feel that what he most fears in himself has been brought under better control, the stage is set for renewed externalized flow of energy into renewed reality interest and reality testing.

The patient may immediately or very quickly feel changed or see himself as different under such circumstances. He then tests whether this feeling of difference in him is real and, therefore, perceivable by others and accepted by others, or is a transitory thing. He does this by observing very closely the reactions toward him of the hospital staff, as well as other significant figures in the milieu or his family. These testing maneuvers are essentially independent of any drug, but in some patients they come into play through the beneficial action of the drug in controlling the significant symptom complexes.

If the patient improves under these circumstances, he does so because he feels changed as a result of being controlled. He has been made better able to use his powers, for he now visualizes himself as a less fearful and fearsome object. Because he is in better control of himself or feels himself to be a more worthwhile being than before, the world becomes a less fearful place whether actually or potentially. The way in which others (doctors, family, relatives, nurses, hospital staff) regard the patient, what they expect of him, the enthusiasm for or rejection of certain therapeutic agents, all may as a result play important roles here. It is at this point that many patients, previously relatively inaccessible to psychotherapy, become potentially accessible, for they become ready to endow the external world with new interest and to use their energies to deal with it.

When these attempts to reinvest energy (cathexis) on to external objects receive sympathetic responses from his entourage (that is to say, from the significant figures in his milieu, be they doctor, hospital, nurses, or family group), ego reintegration continues and the patient remits from his psychotic episode. It is up to the physician to take full advantage of his knowledge of transference, of the patient's testing maneuvers, of the patient's conflicts, and of the patient's

reaction to neuroleptic medication, and to interpret heavily on the side of better interpersonal relations so as to help the patient use his new and very cautiously used "outgoingness" to gain self-confidence. If this is done, the patient responds well. If this situation continues for a sufficiently long time, further ego integration takes place.

Poor Therapeutic Results

When the schizophrenic patient interprets the drug effect as threatening, that is to say, as an assault or manipulative attempt by the physician, or when he feels that it does not help control what he most fears in himself despite the appearance of the characteristic pharmacological effects, the patient either does not get better or can even become worse (13). Sometimes, if the patient initially improves, faulty relationships with his family and significant adults may shatter his newly developing concept of himself as different, and thus curb the externalized flow of energy. Such rejections confirm his worthlessness and his fear of his own impulses; the patient regresses, relapses, or does not get well.

Thus, in schizophrenia the role of medication is to control those "target symptoms" which express the patient's inability to tolerate those of his impulses which represent to him the essence of his conflicts. If these are controlled, this makes the patient more accessible to psychotherapy, more able to channelize energy into externalized contacts and renewed interest in external reality and interpersonal relations. It is at this point that psychotherapy may become more meaningful, and that psychotherapy may be of more direct benefit in the patient's reality testing maneuvers.

Psychotic Decompensation During Psychotherapy

When a patient in psychotherapy (i.e. without concomitant drug therapy) begins to show signs of deterioration of his ego defenses, the signs and symptoms of a threatened eruption of an underlying psychosis can begin to appear.

Increased anxiety, restlessness, irritability, and frightening dreams appear. Sometimes the first warning the physician has is the emergence of an acute psychotic episode with florid schizoaffective or florid paranoid symptomatology, with much affect and agitation. The physician must ask himself which of the symptoms most symbolizes for the patient his feared psychotic deterioration. For example, if the patient cannot sleep and is having nightmares—nightmares which represent the patient's disintegrating mind—the capacity to medicate adequately, to guarantee sleep in the context of psychotherapeutic support, can prove to the patient that the doctor understands the process, and is able to do something about it. Generally, if this is done systematically producing several good nights' sleep and counteracting the sleepless exhaustion that the nightmares have been producing, the patient will often pull himself together and the threatened psychotic deterioration will disappear. Meanwhile, the life crisis that produced it can be fruitfully explored in the supportive psychotherapeutic relationship.

This also holds true when one is doing uncovering psychotherapy, and applies to the decompensating crises that can be occasionally seen even during psychoanalysis (the most intensive form of psychotherapy) of a patient. The symptomatology and the downward progression in the patient's ego defenses indicate that interpretations and the therapeutic relationship are at the moment not necessarily enough. This happens rarely, but particularly with some borderline patients during exploration of weaning and separation experiences (5, 21). In these cases it is very important to medicate the patient adequately, so that what is uncontrollable becomes more controllable, while one continues the psychotherapeutic uncovering or psychoanalytic relationship. Sometimes in psychoanalysis it is necessary to sit the patient up during such a crisis, but on many occasions it is possible to carry on with the patient on the couch, provided that the patient is able to feel that the physician can help him master that which becomes much more dubious and more difficult without these interventions (1, 9). The important thing *in the context of psychoanalysis* is to withdraw all the

drug treatment as soon as the patient can master the situation himself; thus, the use of drugs in this context is a "parameter" to be introduced when needed but to be withdrawn as quickly as possible and in full collaboration with the patient when not needed.

In short, in all the above situations, the concept of a time-limited intervention of a nonpsychotherapeutic kind, only when needed—and only to strengthen the patient's ego and ego capacities—is the principle around which one uses pharmacotherapy.

Anti-Depressant Drugs and Psychotherapy

Psychotropic medication includes the tricyclics, the quadracyclics, and the MAO Inhibitors. These are active psychotropic agents when given in adequate dosage. Again, they produce a characteristic clinical pharmacological profile and, again, this drug action is not specifically curative, but rather helpful. We must remember that the vast majority of patients who consult the physician with a depressive illness consult him for a Reactive Neurotic Depression. These conditions are generally time limited and most patients improve in more than thirty days and within six months to a year, with the vast majority improving in the first six months. Thus, there is an inherent time-related improvement pattern. The majority of such patients are seeking support and the recovery of significant object relationships shattered through loss, i.e. losses which have shattered their inner concept of self. This may be the loss of a job, the loss of a loved one, the loss of a boyfriend, girlfriend, wife or husband, a shattering emotional rejection such as a lack of promotion or getting fired from a position which symbolically represented the persona of the individual. It is the symbolic representation of this event that affects the patient. The presence of *unconscious hope* in the patient should be assessed. The patient who is unconsciously hopeless and thus feels helpless and abandoned cannot really aim his symptomatology at the physician with a demand for resolution. The fact that a patient is able to form a therapeutic relationship with a doctor and aims his

symptomatology at the physician for resolution, even though the patient looks helpless and hopeless on the surface, is an indication of the presence of at least unconscious hopefulness. Its presence and extent have to be used psychotherapeutically.

The physician should maintain the capacity to be a steady, realistically optimistic person, who helps the patient fight through his difficulties in psychotherapy. The target symptom principle is used here. One must remember that the antidepressant medication may temporarily induce drowsiness and have other side effects, but that the main therapeutic effect of the antidepressants is to increase the patient's inner drive towards outgoingness and object relatedness. This takes three or more weeks to become clinically manifest. In this regard, the spontaneous improvement of many patients in more than thirty days, mainly in neurotic but also in some other depressions as well, must be remembered.

The major indication for the antidepressant drugs, in the presence of a supportive psychotherapeutic attitude on the part of the physician, is in the severe psychotic depressions, or depressions with severe psychomotor retardation. This applies equally to the young, the elderly, or the middle aged (i.e. involutional melancholia, psychotic depressions, with marked psychomotor retardation—the so-called endogenous depressions). Many of these patients cannot relate well while depressed. Here the antidepressants, given in adequate doses, improve the patient's capacity to reach outward and become more outgoing in approximately 70% of such patients after at least three weeks of treatment. Often the drugs must be maintained for the length of the depressive episode, but the patient becomes increasingly available for supportive psychotherapy as the improvement increases.

One must remember these patients' propensities to have nothing to do with any part of treatment or anything that is linked with the depressive psychotic episode of this magnitude—i.e., when they are well, they are in a statebound consciousness of being well, and when they are ill, they are in a time-related

statebound consciousness of being ill (19). When one state is present, the other state is absent. Thus, such patients avoid therapeutic contacts of any kind with physicians and with *anything* that reminds them of their illness when they are well. One has to wait for the next episode, if there is one, before one sees the patient again (19).

Antianxiety Agents

Antianxiety agents are not specifically discussed here. They are, as a class, the most abused and overused of all medications. In psychotherapy, mastery of problems is a primary goal; as this is done, it is rare to need antianxiety agents for any length of time.

REFERENCES

1. Azima, H. and Sarwer-Foner, G. J. Psychoanalytic formulations of drugs in pharmacotherapy. *Rev. Canad. Biol.,* (June) 1961, 20:603.

2. Freyhan, F. Neuroleptic effect: Fact or fiction. In: G. J. Sarwer-Foner (Ed.), *The Dynamics of Psychiatric Drug Therapy.* Springfield, Ill.: Charles C Thomas, 1960.

3. Goldberg, S. C., Schooler, N. R., Hogarty, G. E., and Roper M. Prediction of relapse in schizophrenic outpatients treated by drug and sociotherapy. *Arch. Gen. Psychiat.,* Feb. 1977, 34:171.

4. Gottschalf, L. A. Some problems in the use of psychoactive drugs, with or without psychotherapy, in the treatment of non-personality disorders. In: D. H. Efron (Ed.), *Psychopharmacology. A Review of Process 1957-1967.* Washington, D.C.: Public Health Service Publication No. 1836, 1968, p. 225.

5. Harticollis, P. (Ed.). *Borderline Personality Disorders: The Concept, the Syndrome, the Patient.* New York: International Universities Press, 1977.

6. Hogarty, G. E., Goldberg, S. C., Schooler, N. R. et al. Drug and sociotherapy in the aftercare of schizophrenic patients II—Two year relapse rates. *Arch. Gen. Psychiat.,* 1974, 31:603.

7. Lesse, S. Psychotherapy and ataractics: Some observations on combined psychotherapy and chlorpromazine therapy. *Amer. J. Psychother.,* 1956, 10:448.

8. McChie, A. and Chapman, J. Disorders of attention and perception in early schizophrenia. *Br. J. Med. Psychol.,* 1961, 34:103.

9. Ostow, M. *Drugs in Psychoanalysis and Psychotherapy.* New York: Basic Books, 1962.

10. Sabshin, M. and Ramot, J. Pharmotherapeutic evaluation of the psychiatric setting. *Arch. Neurol.,* 1956, 75:362.

11. Shapiro, A. K. Etiological factors in placebo effect. *J. Amer. Med. Assoc.,* 1964, 187:712.

12. Sarwer-Foner, G. J. and Ogle, W. Use of reserpine in open psychiatric settings. *Canad. M.A.J.,* 1955, 73L187.

13. Sarwer-Foner, G. J. and Ogle, W. Psychosis and enhanced anxiety produced by reserpine and chlorpromazine. *Canad. M.A.J.,* 1956, 74:526.

14. Sarwer-Foner, G. J. Psychoanalytic theories of activity-passivity conflicts, and the continuum of ego defenses. Experimental verification with reserpine and chlorpromazine. *A.M. A. Arch. Neurol. & Psychiat.,* 1957, 78:413.

15. Sarwer-Foner, G. J. *The Dynamics of Psychiatric Drug Therapy.* Springfield, Ill.: Charles C Thomas, 1960.

16. Sarwer-Foner, G. J. and Koranyi, E. K. Transference effects, the attitude of the treating physician, and countertransference in the use of neuroleptic drugs. In: G. J. Sarwer-Foner (Ed.), *The Dynamics of Psychiatric Drug Therapy.* Springfield, Ill.: Charles C Thomas, 1960.

17. Sarwer-Foner, G. J. Some therapeutic aspects of the use of neuroleptic drugs in schizophrenic, borderline states and in short-term psychotherapy of the neurosis. In: G. J. Sarwer-Foner (Ed.), *The Dynamics of Psychiatric Drug Therapy.* Springfield, Ill.: Thomas, 1960, pp. 517.

18. Sarwer-Foner, G. J. The role of neuroleptic medication in psychotherapeutic interaction. *Comprehen. Psychiat.,* 1960, 1:291-300.

19. Sarwer-Foner, G. J. A psychoanalytic note on a specific delusion of time in psychotic depressions. *Canad. Psychiat. A. J. Suppl.,* 1966, 11:S221.

20. Sarwer-Foner, G. J. On psychiatric symptomatology: Its meaning and function in relation to the psychodynamic actions of drugs. In: H. C. B. Denber (Ed.), *Psychopharmacological Treatment in Psychiatry.* New York: Marcel Dekker, 1975.

21. Sarwer-Foner, G. J. An approach to the global treatment of the borderline patient: Psychoanalytic, psychotherapeutic and psychopharmacological considerations. In: *Opus Cite* ref. no. 5, 1977, p. 345-364.

22. Uhlenhuth, E. H., Rickels, K., Fisher, S., Park, L. C., Lipman, R. S., and Mock, J. Drug, doctor's verbal attitude and clinical setting in the symptomatic response to pharmacotherapy. *Psychopharmacologia,* (Berlin), 1966, 9:392.

23. Vaillant, G. E. The prediction of recovery in schizophrenia. *J. Nerv. Ment. Dis.,* 1962, 35:534.

24. Winkelman, N. W., Jr. Chlorpromazine and prochlorperazine during psychoanalytic psychotherapy. In: G. J. Sarwer-Foner (Ed.), *The Dynamics of Psychiatric Drug Therapy.* Springfield, Ill.: Charles C Thomas, 1960, p. 134.

25. Wittenborn, J. R. and May, P. R. A. *Prediction of Response to Pharmacotherapy.* Springfield, Ill.: Charles C Thomas, 1966.