

Meaning and Medication in the Care of Treatment-Resistant Patients

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When patients fail to respond to psychopharmacologic treatment, one reason is that the meanings that treatment and/or wellness hold for them are psychologically intolerable. The result may be noncompliance with medications or the repeated emergence of intolerable side-effects, or a defensive attachment to the medications that prevents improvement. When treatment resistance emerges from the level of meaning, it may be that it can be resolved only by addressing it at that level. This paper argues for the importance of integrating psychological understanding into the pharmacologic treatment of treatment-resistant patients, and explores some factors that mitigate against integration. Several treatment vignettes are presented, suggesting ways of working with meaning in relation to pharmacology. Finally, the paper explores benefits of integration for treaters, even if integration does not result in the resolution of treatment resistance.

INTRODUCTION

The problems our patients face are many and varied. Disturbances in brain chemistry, broken lives, distorted expectations, and pathological adaptations often combine to produce psychiatric difficulties that are not solved simply with medications, and call for attention to more than one level of the biopsychosocial spectrum. When a patient does not respond to a unimodal treatment, addressing problems at other levels in an integrated, and not just additive, fashion may allow previously ineffective treatments to work. This may be the case where the explicit and implicit expectations that the patient brings to pharmacologic treatment are in some way in opposition to a therapeutic effect. For these patients, the exploration of, and active engagement with, the idiosyncratic meanings that medications hold for the patient and in the doctor-patient relationship can be crucial in allowing the medication to have a desired therapeutic effect. In this case, the psychopharmacologist's capacity for psychodynamic understanding

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and skill with psychodynamic techniques may be important ingredients in overcoming treatment-resistance.

THE DECADE OF THE BRAIN

This is an exciting time in the practice of psychiatry. Over the past several decades, the increasing rigor in objective-descriptive psychiatry has improved our ability to usefully differentiate discrete psychiatric disorders. Applying the principles of evidence-based medicine, we can be increasingly confident that our approved pharmacotherapeutic armamentarium has more than fantasied clinical usefulness. At the same time, advances in the neurosciences seem to be coming at an exponentially increasing rate. We are becoming even more sophisticated in our identification of neurotransmitters and receptors and their respective subtypes. For the first time, psychiatric medications are being found not just serendipitously, but our burgeoning understanding is now allowing medications to be crafted specifically to interact with receptors whose functions we are beginning to comprehend. The tremendous optimism and the explosion of understanding in the neurosciences have led some to call this past decade the “decade of the brain” (1). These changes are lending to our field a renewed respect in the medical world.

However, these same developments also threaten the very existence of psychiatry as an independent discipline. The formal distinction between structural (neurological) mental diseases and functional (psychiatric) ones is being erased as we begin to make sense of smaller and smaller structural units in the brain, units now identified at the macromolecular level. Consequently, respectable figures in the fields of psychiatry and neurology are arguing that psychiatry should be collapsed into neurology (2). At the same time, with a biological simplification in the understanding of psychiatric symptoms and with the increased safety profiles of the newer medications, primary care physicians are now prescribing the majority of psychotropics. These developments have led others (3) to argue that psychiatrists should prepare to become primary care doctors out of economic and political necessity.

THE ECONOMICS OF MEANING

The advances in neuroscience are currently being coupled with widespread political and economic changes in the practice of psychiatry (3, 4). Managed care has led to a focus not only on effectiveness, but also to a focus on efficiency. Though most skilled psychopharmacologists have probably experienced being able to integrate medications and psychody-

namic understandings in ways that have been uniquely useful to individual patients, the field of psychiatry has not produced evidence from larger studies that support the claim that combining these elements into a single treatment is useful to our patients. Consequently, psychiatrists are increasingly being relegated (or is that elevated?) to the role of medication administrator, while therapy is left to professionals and paraprofessionals with nonmedical training.

Though there is greater agreement that some capacity for psychological understanding is important to the competent functioning of even a biological psychiatrist (5), our ability to educate psychiatrists-in-training about psychodynamics is threatened. In the heyday of psychodynamic psychiatry, when medications were new and our understanding of the brain even more primitive than it is now, 3,000, i.e., 50% of the 6,000 hours of a psychiatric residency training were devoted to long-term psychotherapy. Today, with an overwhelming amount of neurobiology to master and serious questions about the relevancy of psychotherapy for psychiatry, long-term psychotherapy training requirements have been reduced to 200 of the now 8,000 hours, or 2-½ %, of residency training (6), and influential academicians are proposing that psychotherapy training be eliminated from psychiatric residencies altogether (7).

LIMITS OF THE MEDICAL MODEL

One of the greatest strengths of the current medical model is the rigorous insistence on sound evidence for the usefulness of accepted treatments. Ironically, the strength of the current model may highlight its weaknesses. Thomas Kuhn (8), in *The Structure of Scientific Revolutions*, suggested that, as a science grows and becomes more rigorous, it will more consistently encounter its limits as an explanatory model. As we usefully differentiate effective treatments from ineffective ones, the limitations of current pharmacologic treatments for mental illness become more and more apparent.

Over the last 20 years, there has been an exponential growth in the number of medline citations concerned with the issue of treatment-resistant mental illnesses, with the number of references doubling every 5 years. Even with our current level of understanding, it has become apparent that a minority of depressed patients will have a full recovery on medications (9), and a significant proportion of psychotic patients may be classified as neuroleptic nonresponders (10, 11). There are many reasons why patients do not respond adequately to medications. One reason is that a strictly medical approach ignores psychological and social factors that impair the patient's ability to make use of medications.

Even where we can show medications to be effective, our methodological paradigms point to the limitations of a purely biological understanding of psychopharmacologic action. The gold standard of the placebo-controlled trial has been used better to isolate and identify substance-specific biological mechanisms, and has been used to argue convincingly for the biological effects of our treatments. But, separating out placebo effects from "treatment" effects reveals how much of the therapeutic response to psychotropics powerfully derives from the meaning invested in those substances. Countless studies show the placebo effect to account for 50-75% of the therapeutic benefit of antidepressants (12-17) and anxiolytics (18, 19). Even strong proponents of a biological psychiatry approach note that such biologically based illnesses as bipolar disorder (20) and schizophrenia (21) show a placebo response rate to medications of 25-50%.

AMBIGUITY AND COMPLIANCE

There are many reasons that our medications are ineffective; one of these is noncompliance. *Usually*, a medication will not be effective if the patient does not take it. The degree to which noncompliance is a problem in psychopharmacological treatment is impressive. Roughly a third of patients are completely noncompliant with prescribed medications (22), and another third are only partially compliant (23). Contrary to rational expectations, the patient cannot be counted on to be an ally, and may even be an adversary. One reason for this is that the pharmacologic effect of a medication and its meaning may be in opposition (24-26). Patients, even while desiring to be rid of symptoms, may value them. Their symptoms may be necessary for secondary gains, such as the opportunity to be treated in the sick role. Patients may find that their infirmities have paradoxically given them more power over others than they ever had without those symptoms, or may free them from unpleasant or overwhelming obligations. Symptoms may help patients manage intolerable affects. Refractory symptoms may also become a powerful currency within the psychopharmacologist-patient relationship, expressing a full range of unspeakable wishes, from a boundless desire to take in the doctor's caring to a hostile wish to frustrate an envied caregiver. For patients with a tenuous sense of self or patients who have been controlled and harmed by others, ingesting a substance that is intended to alter some aspect of their experience (even though for the better) often produces profound paranoid anxieties (27). These patients may attempt to reestablish a sense of equilibrium and control by refusing to be controlled by the psychopharmacologist's treat-

ment recommendations, taking either too little or too much medication according to their own wishes.

Addressing the noncompliance at the level of meaning may help some patients to overcome this kind of resistance to using medications reasonably and benefiting from them. In some cases, the psychodynamically informed prescribing psychiatrist may be in the best position to help the patient identify sources of ambivalence so that he/she may choose more consciously either to comply with or refuse the treatment.

A recent pilot study at the Austen Riggs Center (Mintz, unpublished data) supports this proposition. The Austen Riggs Center specializes in the care of treatment-resistant patients, combining psychodynamic, psychopharmacologic, and community treatments, and providing rich sources of data on the interactions of dynamic, psychopharmacologic, and social factors. The psychiatrists on staff provide integrated psychodynamic and psychopharmacologic treatments to their therapy patients, and medical back-up for the psychologists on staff. In this style of work, it would be usual to regard acting out with medications as having deeply personal meanings in the relationship between therapist and patient. The pilot study was undertaken to explore an interdisciplinary disagreement between the psychiatrists and psychologists. The psychiatrists were feeling at times abandoned by the therapists, particularly in times of crisis when the staff would turn with frustration to medications for a solution. The prescribing psychiatrists were concerned that the psychologists were not feeling a sense of connection to the psychopharmacologic aspects of the work, and were consequently having difficulty engaging this as a felt aspect of the therapist-patient relationship, or transference. The psychologists were unaware of there being a problem.

To address this issue, rates of compliance for patients in split and combined treatments were studied. Patients in a combined treatment were, on average, 11-13% more compliant with their medication regimens. This study is being followed up currently with a more rigorous methodology, but it suggests that the prescriber's felt connections to the medications, coupled with the capacity to explore in depth the patient's attitudes to both the doctor and the medications, may significantly improve the patient's ability to make use of medication.

Even when medications are taken compliantly, the underlying meaning of the medication and the patient's attitudes towards wellness may profoundly impact medication effectiveness. In a study of psychological factors that predict a positive drug response, Beitman et al. (28) administered a scale assessing psychological readiness to change to patients

participating in a placebo-controlled trial of a new benzodiazepine for anxiety. They found that psychological readiness for change was the single most important predictor of a therapeutic response, even more powerful than drug-group assignment. In this evidence-based health care environment where there is increasing attention to the mechanisms of treatment-resistance, this important study has received surprisingly little attention. The neglect shown here to the significant role of nonpharmacologic factors in medication response is also shown in our neglect and disparagement of the placebo response.

MEANING AND HEALING: THE PLACEBO

The ingestion of putatively psychoactive substances may have profound effects at a symbolic or psychosomatic level. The medication may exert an effect because of the meaning that it has to the patient. This is uncontroversially the case with placebo effects. That placebo effects account for the majority of an antidepressant response highlights the tremendous importance of meaning for an individual's symptoms and functioning. The fact that placebos also induce real neurobiological changes (29) further underscores that meaning effects are not mere fantasies, but may also unleash true healing functions. Though psychiatry has concerned itself with the conjunction of meaning and biology (or bio and psycho and social) for most of the past century, placebo effects have tended to be discounted and ignored. There are many reasons for this phenomenon. One reason that placebo effects have been uninteresting is that they are so general and ubiquitous and do not require a great deal of skill or training to engender. They are beneath us: one does not need to be a doctor or scientist of meaning to marshal the patient's conscious hopes and expectations to support the patient's healing. Placebo effects are also discounted and ignored because they are seen as an embarrassment to psychiatry (30). For many, these comparably large meaning effects in psychopharmacology undermine the effort to place psychiatry soundly amongst the physical sciences. Furthermore, to the extent that mobilizing the power of suggestion and manipulating the patient's desires for relief or care are routinely a deliberate aspect of prescribing, placebo effects may also be an embarrassment for a field that particularly values honesty and informed consent.

Finally, placebo effects may be protected by our lack of attention to them. Currently, meaning effects in psychopharmacologic treatment tend not to be seen as real and powerful expressions of unconscious defensive and self-healing capacities. Instead, they are disparaged as *mere* placebo effects, unreal because of their psychic origins. Consequently, the recog-

nition of nonpharmacologic components of a medication response could potentially undermine those clinically significant effects that the patient could otherwise acknowledge and eventually take ownership of. As Sigmund Freud (31) has recommended, one should not interpret a positive transference if it is not being used as a part of a resistance, but as a vehicle of change. Calling attention to the placebo aspects of healing may deprive our patients of some of the most powerful sources of healing at their disposal. It would seem much more useful to call attention to the meaning effects of medications when those meanings were used in the service of resistance.

NOCEBO EFFECTS

Hopeful prescribers are less often aware of the idiosyncratic and negative effects of medications that are mediated through a patient's symbolic world. When a patient experiences harm as a result of expectations of harm, the patient has experienced a nocebo effect. These effects may be profound, as in the phenomenon of voodoo death (32). In voodoo death, the expectation of harm is explicit and shared, as is usually the case with the placebo effect. But expectations of help or harm may also be implicit (33) or unconscious. An implicit and diffuse expectation of harm may unleash nocebo responses. In a sociological study of the nocebo effect, Hahn writes:

Within cultural settings, certain social, and/or psychiatric circumstances increase the susceptibility to available nosological conditions. Role burden, role incongruity, and role conflict, as perceived by people in response to cultural values and personal identity, may increase the risk of nocebo events, which may be experienced as powerlessness. Persons who find their social positions intolerable or otherwise unavoidable are at increased risk for nocebo experiences; this fact could help account for the greater incidence of nocebo phenomena among women and persons from lower socioeconomic classes. (34, p. 70)

In other words, nocebo effects have particular relevance to our patients, many of whom arrive to treatment with deep-seated expectations of harm by others. Because these expectations of harm are conditioned largely by the individual patient's life experiences rather than by the doctor, nocebo effects in psychiatry tend to be quite idiosyncratic, and can often be recognized only by exploring the patient's life history and the explicit and implicit expectations they derive from this life history.

In my practice specializing in treatment-resistant patients, I have been impressed by the extent to which meaning complicates psychopharmaco-

logic treatments for these patients. Often, by the time that these patients come to Austen Riggs, they have been on every major class of psychotropic in a multitude of combinations. In many instances, the repeated emergence of intolerable side effects prevents them from benefiting from their medications. In those cases where the difficulty emerges from the level of meaning, it appears that only addressing the problem at the level of meaning can ameliorate it.

Vignette 1

A., a 25-year-old male, presented with diagnoses of Major Depression, OCD, panic disorder, as well as narcissistic and obsessive-compulsive personality traits. He came from at least three generations of irritably obsessive people. Unfortunately, his obsessiveness was misattuned to that of his family, who regarded him as cranky and demanding from infancy. Consequently, he felt that his family was always trying to “hush” him. He sought treatment for crippling obsessionality in his thought processes, unremitting depression with suicidal ideation, intense lability of mood, and chronic insomnia related to nightly panic attacks. Psychopharmacologic treatment had been unsuccessful despite multiple trials of antidepressants, mood stabilizers, antipsychotics, and anxiolytics.

In an integrated treatment, A. was begun on a trial of an antidepressant and a mood stabilizer. Soon he began to complain of neurasthenia and intolerable feelings of emotional deadness. The therapist-prescriber experienced A. as more organized and able to engage productively in the therapy, but A. felt that he was too cut off from his emotions to engage. Over the ensuing weeks, A. would masochistically attack himself in a sideways attack on the therapy whenever he felt slighted or misunderstood, which had been his style. However, it became clearer that the attack had a specific character. With increasing frequency, he would make statements like: “Oh, just put me in a cage and throw a blanket over me,” or “just take off the top of my head and scoop my brains out,” or “can’t you just turn me into a zombie?” He stopped the medications, and the complaints continued.

Then the therapist interpreted the patient’s concern about being contained and controlled by the therapist and his medications. Exploring this issue, A. realized that he felt the therapist had prescribed his medications in order to “hush” him. Acknowledging that this expectation was possibly contributing to side effects of numbness and neurasthenia, A. agreed to continue the medication. The side effects resolved quickly, and he became panic-free and able to sleep for the first time in his adult life.

This improvement led to a notably greater ability to make use of his psychotherapy. Though still dysphoric, the crippling fear he experienced is ameliorated, and he has continued to take his medications in the context of a therapy that focuses a great deal of attention on his ability to trust, count on, and make use of people.

This case shows how an expectation of harm, conditioned in early childhood, emerged as a nocebo effect that repeatedly impaired the patient's use of clinically beneficial medications. It also shows how the therapist-prescriber was in a position to experience the meaning of patient's side effects in the doctor-patient relationship and to explore their meaning and origins, such that the patient was able to be freed to make good use of the medications. In a split treatment, it would be unlikely that the psychopharmacologist would have integrated enough of the life history to realize how the side effects emerged from the patient's conditioned expectations of harm. Furthermore, a therapist who had not prescribed the medications might less easily experience the psychodynamic implications of the patient's side effects. Consequently, the patient would be deprived of an opportunity to master the meaning effects that so interfered with a positive drug response. The side-effect-prone and treatment-resistant patient may be best served by a treatment that does not just add psychopharmacology and psychotherapy, but rather one that integrates these two approaches to a high degree.

MEDICAL MEANING

The psychopharmacologist, too, brings a range of meanings and expectations to the psychopharmacologic relationship, and these may profoundly affect the patient's response to, and use of, medications. Most straightforwardly, this is the case when the physician's hopefulness about a psychopharmacologic treatment is transmitted to the patient and helps to elicit a robust placebo response. However, other meanings are evoked by the act of prescribing, which can be very complicated for both the doctor and patient. Some of these meanings are quite personal; others expectably emerge from a medical system of meaning.

Beginning in the first few weeks of medical school, the medical student is introduced to his or her first patient: the cadaver. Passive and compliant with the doctor's every intention, this patient begins to teach the physician-in-training a medical stance. Some of the prevailing metaphors of medicine, such as the war metaphor (35), deepen the impact of these earliest lessons. In the war metaphor, the patient becomes a more or less passive biological substrate for the battle between the doctor and the disease.

Similarly, Docherty et al. (36) described a common phenomenon where the model of dispassionate scientific observer is incorporated into the act of prescribing to evoke a "subject-object" mode of relatedness. In a subject-object mode of relatedness, the patient is experienced as an object that reacts biologically to a substance rather than as a subject whose motivations and experiences are of significant importance.

The "delusion of precision" (37) is another ingrained medical value that may interfere with the experience of the pharmacologic patient's subjectivity. In a medical-scientific framework, assumptions are made that clinical effects derive from concrete, specific, precise, and straightforward characteristics of the drug and its interactions with the biological substrate. Though it is easy to make these assumptions, we do not always know how medications heal our patients. Is it a placebo effect? Does the patient improve because he or she experiences the prescription as a caring validation in the doctor-patient relationship? Does a pill provide a fantasy of being in control that emboldens the patient to begin to take control of his or her life? Are side effects the result of the patient's defensive needs for control or expectations of harm? Questions such as these are infrequently asked when there appear to be positive or negative medication effects. The ways that a biological system of meaning is activated by the act of prescribing may obscure, even for a psychodynamically informed prescriber, the tremendous impact of the patient's subjectivity in psychopharmacologic practice.

Medical meanings may also be transmitted to the patient in a way that obscures the patient's subjectivity to him or herself as well. Medications can be, for our patients, a form of interpretation, albeit an inexact interpretation (38). Often, the interpretation that is proffered (and/or heard) is that biological mechanisms account wholly and completely for the patient's symptoms and problematic behaviors, that the patient is simply a victim of "chemical imbalance." For some patients, this (inexact) interpretation is extraordinarily powerful.

Though these dynamics apply to many patients, they are especially true for patients with primitive splitting defenses. Whether or not these patients have a bipolar disorder, they are often prescribed mood-stabilizing agents to help contain mood lability. These borderline and other primitive patients often struggle with a sense of inner badness. They attempt to deal with this badness by intrapsychically splitting themselves into good and bad parts, projecting the original badness into some other, who then becomes responsible for the badness. Patients who rely on splitting defenses may enthusiastically take the physician's biological explanations

and optimism about a medical cure to mean that the badness is located solely in a biology for which the patient feels little responsibility.

Physicians may offer this kind of inexact interpretation accidentally, or in response to the empathic pull to relieve the patient of painful self-hatred, or in order to create an alliance that may allow the psychopharmacologist to be of some real use in the future. Such a medical interpretation will often successfully relieve some of the patient's dysphoria. However, affirming the patient's sense of victimhood and helplessness before an inexorable biology frequently has a negative effect on the patient's behavior, adaptability and quality of life, becoming either a license to act badly "because of my bipolar disorder," or providing crippling evidence that impulses and feelings are unmanageable (Belnap, unpublished paper). For these patients, it may be especially important that the psychopharmacologist recognize the medical meanings that are brought to the psychopharmacologic relationship, and to temper them with a psychodynamic self-awareness, an understanding of what medications mean to the patient, and a humility about the true limitations of pharmacologic treatments.

Vignette 2

Ms. B. is a 29-year-old woman with a history of bipolar disorder, PTSD, and borderline and narcissistic character traits. Since early adolescence, she had a history of falling into dangerous relationships. After being date raped, dissociation emerged as a preferred defense. In early adulthood, she was treated for depression, and became manic while on antidepressants. At that time, her life was characterized by intense mood swings with as many as 20 "hypomanic" moods lasting from a few hours to two weeks, superimposed on a chronic picture of depression, affective numbing, and collapse in the face of any attempt to separate meaningfully from the family. She had been less impulsive since being prescribed mood-stabilizers.

B. sought admission at the Austen Riggs Center because of an impenetrable inability to feel. She was living at home, and had been unable to work, sleeping long into the morning and having profound difficulties with motivation and a feeling of hopelessness. Her parents regarded her as an invalid. Though they supported her treatment in the hope that she would be less depressed, they planned for her to continue living with them and then to receive continued custodial care beyond the end of their lives.

In her initial psychopharmacologic evaluation, she spoke of her difficulties almost exclusively in psychiatric jargon, quickly labeling her behav-

iors as "bipolar." The psychopharmacologist had a vague but immediate feeling that she was attempting to engage him in a medical system of meaning to use as an ally against the threat of actual therapy. The reasons why she needed to do so would only become clear much later. The psychopharmacologist tried to explore her apparently defensive use of the meanings of her medications, and she noted that a biological "label" was comforting to her, helping her to feel less guilty. Alerted to the possibility of an early splitting maneuver along biological lines, the psychopharmacologist discussed this with the new therapist, who was also aware of these dynamics in this patient. These defensive efforts were engaged as a part of the therapy, and the defensive use of medical meanings gave way to a new curiosity about her inner life.

In time, it became apparent that B.'s medicated, passionless, amotivational presentation had important meanings in the equilibrium of the family. The medical effort to contain her feelings was supported by her family, who legitimately feared for her safety. However, they also regarded any heartfelt connection to the world as a real threat to the family and strove indirectly to undermine any sense of aliveness or competency in the patient in order to preserve their mutual dependency. The outpatient psychopharmacologist had implicitly agreed by setting the containment of intense emotions as a goal and by regarding this bipolar patient's calm as a therapeutic success without understanding the deep and countertherapeutic uses of the medication.

Without the unwitting collusion of a "successful" psychopharmacologist operating in a medical system of meaning, the patient could more clearly face difficult questions about the meanings of her current symptoms, and began to develop a sense of herself as capable of having and managing intense feelings. Though this created panic in her family, she was able to form connections outside the family, first making a choice to continue in her therapy rather than return home, then choosing work and romance over her therapy. While she continued to exhibit questionable judgment in her relationships, she was now undoubtedly alive, both to herself and others.

MEANING AND COUNTERTRANSFERENCE MANAGEMENT

Though a psychodynamic understanding of the meanings of medications may help a patient to break out of an intractable period of treatment resistance, it is also quite common for a treatment-resistant patient not to be helped by such an exploration. Ideally, this would be because the patient was able to make a more or less conscious choice, but, more often

than not, the patient simply cannot bear the awareness of the conflicting meanings and uses of his/her symptoms and medication reactions. Even if an understanding of the meanings of the medications does not help the patient, such an understanding may still help the psychopharmacologist.

Working with treatment-resistant patients can be taxing. After a while, the repeated failures can turn into nihilism, or desperation, or rage (39), particularly when the patient seems to participate in defeating one's best psychopharmacologic efforts. If the patient is not rejected (11), the efforts to treat the patient get more desperate (or sadistic), and the regimens get more complicated. The side effects get more disabling as medicines are piled on top of medicines. A psychodynamic understanding of the patient's transferences to the medications and/or psychopharmacologist may help the physician to manage the powerful countertransferences that may be evoked. Understanding may be crucial in maintaining a benevolent neutrality.

Vignette 3

Ms. C. is a middle-aged woman with chronic, undifferentiated type schizophrenia. Despite this, she was able to organize herself enough to competently raise a child with support from her parents. Then, her son succumbed to cancer, sending her deeper into psychosis. She sought treatment at her family's urging for a treatment-refractory psychosis. It seemed that she could only tolerate those antipsychotics that were ineffective. It quickly became apparent that she feared getting well. More often than not, the psychosis was comforting. The voices were friendly. At times, her tremendous loneliness would erupt through the psychosis, at which point she would become amenable to medication changes that might be effective. Invariably, she would become frightened that she would get depressed from the potentially effective medications and kill herself. Then, she would develop intolerable side effects and discontinue her medications, going back to medications that were relatively ineffective. Her preoccupation with her dead child and psychotic conviction that she could bring back the dead and cure various deadly diseases revealed the powerful logic behind her treatment resistance. If she became nonpsychotic, then her child died forever, and she feared that the grief of this would kill her. The efforts of the psychopharmacologist to help her make this important connection were understandably in vain.

In this case, understanding some important dynamics underlying treatment resistance did little to help the patient. However, the interpretation was very helpful to the psychopharmacologist. The patient's resistance to

treatment made perfect sense. The psychopharmacologist's sense of frustration and rage at being so rejected and useless was tempered with an empathic understanding that sanity felt, in a powerful sense, deadly for her. It allowed the psychopharmacologist to work with her for a number of years and allowed him to remain safe enough to her that she could keep trying new medications that might offer her some hope of wellness.

CONCLUSION

In summary, I wish to reiterate that the mind-brain barrier (37) is more spurious than real. Alterations in the biochemistry of the brain can change the ways a person experiences, and experiences, expectations, and meanings can alter the biochemistry of the brain. This does not mean that the mind and brain are identical. The biological effect of a medication may be either concordant with or antithetical to its meaning. When the biological and meaning effects of a medication are concordant, the therapeutic effect of the drug may be enhanced (28). When the intended therapeutic effect of a medication and its meaning are in conflict, the meaning of the medication may severely impair the ability of the medication to be effective. The ability to treat the patient on both these levels, not just additively, but in an integrated fashion, can only strengthen the efficacy of the psychiatrist. But, the field of psychiatry is in danger of losing a significant part of our therapeutic inheritance. The current pressures from within and outside of psychiatry to biologize psychiatric practice at the expense of attention to psychosocial factors threaten to impoverish our discipline so that it is indistinguishable from other fields, such as neurology or primary care medicine. The cost to some of our treatment-resistant patients is incalculable. The cost to our profession is enormous, too, as the integration of meaning and biology, more than anything else, lends to our discipline its particular power, and gives us skills for working with particularly troubled patients.

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