balloons to convey the cumulative effects of stress and anxiety. Furthermore, techniques for involving young children in eliciting the family system, communicating feelings, setting goals, structuring change, and reassessing the family system. There is emphasis on the importance of incorporating play into family sessions as a medium of communication. Such family sessions are treatment in their own right or preparation for the child to be seen in individual treatment.

Thus, child treatment and family therapy have been combined or have enriched each other, and the use of play is a common ground between the two approaches.

An integrated approach that combines play therapy and family therapy is particularly useful for addressing symptoms in young children and helping the parents to learn about developmental characteristics of young children and how to enhance their learning through play.

**Integrating Parental, Educational And Community Resources With Psychopharmacology:**

Families, teachers, community representatives, patient advocates, pediatricians, and other practitioners are central to all aspects of research and management including hypothesis development, study design, implementation, and knowledge exchange. Without their input and support, pediatric management and research will be difficult to conduct and of limited influence. Lack of communication between community tools and psychiatrists has been a serious obstacle and often translated into suspiciousness toward treatment services and misconceptions about its purposes. Under such conditions, the stigma traditionally attached to mental illness renders psychopharmacological research even more difficult to conduct.

Some investigators still do not evidence adequate understanding of the family context and appreciation of the importance of cultural factors in determining attitudes, expectations, concerns, and biases. The training of clinical investigators has far ignored these essential aspects of intercommunication. Confusion between the roles of research and medical provider can generate misunderstanding and disappointment, especially if research participation is seen as the only opportunity to receive care.

Adequate feedback is not always given to parents and physicians during and after studies, thus inducing a feeling of being "used" for academic exercises of little personal relevance. Ultimately, participation in research should be viewed by children and families as an opportunity to gain personally relevant knowledge, in addition to a contribution to the advancement of science.

**Azza EL-BAKRY,**
**M. Sc., M.D.**
**Professor of Psychiatry**
**Cairo University**

## Mini-Reviews

# Psychodynamics of Pharmacotherapy

*By*

**Hanan El-Shinnawy**

**Introduction:**

Through out history 1940, 1950 psychoanalysis dominated landscape of psychiatry and there was reluctance to combine medications with psychotherapy for fear of:

- Psychortropic medications alleviate anxiety and depression that motivate patient to tolerate frustration.
- Interference with development of transference and its role.

The belief of incompatibility of psychotherapy and medication persisted to the 1960, 1970 despite the opposite results of the studies.

Although at a while Anna Freud was convinced that addition of medication allow analysis to continue.

## Specific Diagnostic Categories

**Schizophrenia:**

Integrated therapy reduced relapse rate by affecting high

E.E, social training and adjustment, as well as improving compliance factors.

- **Major Depressive disorder:**

Different target symptoms in patients are attacked. Medications work more rapidly than psychotherapy so relief acute distress. Psychotherapy enhances social functioning so extend the relapse free period.

- **Bipolar I Disorder:**

Combined therapies lead to reduction in relapse rate and hospitalizations. Patients no longer view themselves victims of illness beyond their control and gained sense of mastery over the illness. Patients need assistance in mourning loses during manic phase. Assistance of patients to identify the stressors that produce the relapse.

- **Personality Disorder:**

Combined treatment suggested that medications may affect temperaments while psychotherapy address character.

**One Person Model Therapist**

Psychiatrists must accustom themselves to think about both E.E, social training and adjustment, as well as improving mind and brain, and require flexible shifting back and froth between

empathic, introspective subjective approach versus a more objective descriptive approach.

**Advantages:**

1- Psychotherapy and drug prescribing do not get split off from one another that fragment the treatment.
2- All transference and resistance are dealt with on the basis of clinician's knowledge of the patients.
3- Compliance problem could be dealt with on the basis of clinician's knowledge of the patients transference paradigms and internal object relations.

**Two Person Model**

Clinicians have to be involved if non-medical therapist does psychotherapy. But it runs the risk of serving a nidus for splitting particularly with patients with borderline personality.

**Rules:**

1- Communication between therapists.
2- For forensic aspects written agreement should be signed between 3 partners that include:
   - Purpose of each treatment .
   - Role of each therapist
   - Polices of communication.
   - Supervising responsibility.
   - Who to called in emergency?

## Dynamics of Pharmacotherapy

The phenomenon of non-compliance could be understood with the aid of psychodynamic concepts such as transference, counter transference, resistance and therapeutic alliance.

**Transference:**

- Psychiatrist prescribing medication is a transference figure.
- Patient's decision to comply or not with the doctor's recommendations activates unconscious issues of parental expectations.
- Patient's refusal taking medications makes the psychiatrist become more authoritarian insisting that their orders to be followed. This backfires and exacerbates the transference disposition to see the doctor as a demanding parental figure.

**Different Reactions:**

- Patient may need to look for someone to validate his feelings instead of medicating him or her.
- Patients with tendency to be controlling or dominating will see medication as a threat and pills means submitting to domination of powerful parental figure.
- Submissive patients taking pills make them feel fed and taken care of to an extent thathey may no longer need to take responsibility for any aspects of their illness.
- Manipulation and rejection of patients defeat every treatment intervention that could be due to great deal of resentment and bitterness towards parental figures. Patients unconsciously seek revenge against their parents and when they sense making their doctors miserable, they often feel a secret triumph.

**Transference to Medications**

This is a unique aspect of transference that may:

- Lead to decompansation in chronic patients once they change or alter their medications rituals.
- The transference relationship to a medication may be obvious in situations where the pill take place of the absent doctors (transitional object) maintain some relatedness with their therapists.
- Placebo responses that depends on transference, suggestion, guilt reduction, persuasion, cognitive and conditioning roles.

## Counter transference:

Prescribing medication can be contaminated by counter transference as other treatments interventions.

One common manifestation of counter- transference is over prescription that may reflect:

- Despair of the psychiatrist.
- Narcissistic injury.
- Intense psychiatrist anxiety.
- Psychiatrist anger due to the patient's non-compliance.

## Resistance

Resistance to treatment is as powerful force in Pharmacotherapy as in paychotherapy.

### In Psychotic Illness

Illness be preferable to health due to:

- Preferring the experience of psychotic grandiosity.
- Denial of illness.
- Stigma of psychotropic agents.

### In Non Psychotic Illness

- Fear of being convinced to be more seriously disturbed than they like to think.
- Unconscious identification with a related psychiatric patient especially with unfavorable outcome.
- Deny illness.

## Therapeutic Alliance

This plays a crucial role in dynamic Pharmacotherapy.

Aspects of the therapist's behavior should include:

- Vocal enthusiasm.
- Body of patients name.

At a point in the first interview psychiatrist should explore their patient's expectations. If the treatment of choice is counter to a patient's pre-convinced notions, an educational effort may be necessary.
The variable of the patient's education positively influences the development of therapeutic alliance in Pharmacotherapy.
Patients should be informed about therapeutic and side effects of any pharmacological agent.

## Combined Treatment

Despite the history of polarization between psychotherapists and pharmacotherapists, the combined treatment is a time honored clinical practice in psychiatry.

Today question is not combined treatment is better or not but ; *HOW THE COMBINATION IS BENEFICIAL ????*
Clinicians should be aware of the bimodal relatedness inherent in dual role. The patient must be viewed simultaneously as disturbed person (that requires an empathic subjective approach). And a diseased central nervous system (that requires objective medical approach).

**Hanan El-Shinnawy,**
**M. Sc., M.D.**
**Lecturer of Psychiatry**
**Cairo University**