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Medication and the Fragile Alliance

The Complex Meanings of Psychotropic Medication to Children, Adolescents, and Families

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The past 10 years has seen a marked increase in the use of psychotropic medications to treat children and adolescents. Although there is considerable controversy about this trend, it seems inevitable that multimodal treatments including psychopharmacological interventions will need to be better understood and integrated if we are to provide effective treatment to the largest range of patients. In this article, we offer some observations from our clinical experience regarding the effects of medications on the alliance, transference, and family system. In particular, we examine some of the complex psychodynamic meanings of medication that can dramatically affect response to both medication and psychotherapy.

A CHILD OR ADOLESCENT CAN RESPOND TO THE SUGGESTION TO TAKE A psychotropic medication with reactions that range from guarded optimism to rigid refusal. Child and adolescent psychiatrists who provide integrated treatments, prescribing medication and providing ongoing psychotherapy, are well positioned to evaluate the risks and benefits of medication while exploring the ambivalent responses of their patients initially and throughout the course of psychotherapy. This combined

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treatment role has become less common, almost a luxury, considering the prevalence of managed care, the shortage of child psychiatrists, and an increased pattern of prescribing complex and multiple medications to children and adolescents (Walkup, 2003; Zito et al., 2003). In this time of extreme pressure to manage children's symptoms with psychotropic medication because of presumed biological etiologies and anticipated rapid response, it is critical for both prescribing and nonprescribing psychotherapists to anticipate the significant psychological meaning of medication to children, adolescents, and families.

We have observed that information obtained in the psychodynamic assessment and formulation may be especially useful in understanding the emotional response of both child and parents to medication. In particular, understanding the impact of psychodynamic factors on the therapeutic alliance is often crucial for the acceptance of recommendations and for maintaining reliable communication with adolescents and parents. For example, the clinician might feel that an adolescent struggling with an authoritarian and critical parent might be "forced" to refuse any recommendation enthusiastically supported by that parent, so the clinician might ask to discuss his recommendation with the adolescent first. Understanding that parents are involved in a bitter custody battle, the child psychiatrist might see that he must obtain the agreement of each parent separately before proceeding. There are times when a child or adolescent who initially rejects medication may develop enough trust during ongoing psychotherapy to speak of the "real" reason for the refusal, which permits reassurance or alerts the clinician to areas that need to be examined in the psychotherapy. The adolescent may benefit from the increased self-reflection gained in the psychotherapy to acknowledge his symptoms and their impact and ask about medication. He may also clarify that his rejection was based on sound knowledge of his own symptoms not yet shared with the clinician. If the adolescent tries medication, the psychiatrist is positioned to understand the symptom response and process the patient's feelings if deleterious side effects occur. Overlooking these critical aspects can potentially undermine young patients' success with both medication and psychotherapy.

There are, however, complexities in "wearing two hats." The role and function of prescribing medication may involve asking questions about physical or sexual matters that have not been discussed in the psychotherapy, ordering blood tests or giving direct advice. In addition, pediatric psychopharmacological evaluations and ongoing trials of medication invariably require more contact and discussion with parents. These factors can alter the teenager's view of his therapist and raise issues of confidentiality

and loyalty. At worst, such concerns can adversely affect the transference and countertransference or rupture a therapeutic alliance that took months to develop. In our experience, these shifts that are required in the actual relationship with the parents need to be closely monitored and, preferably, discussed with the adolescent beforehand. If either the clinician or his adolescent patient feels strongly, then it makes sense to split the roles of therapist and psychopharmacologist. On the other hand, we have noticed that the increased interaction with the family that occurs when the clinician adopts the prescribing role often works to facilitate individual psychotherapy. This is consistent with models of adolescent treatment that integrate psychodynamic and systems (especially family) theories.

Hazards exist for clinicians who do not prescribe medication as well. They can become frustrated that communication with the child or adolescent psychiatrist may not be up to date or detailed enough. In many places, due to shortages and other factors, pediatricians, pediatric neurologists, or nurse clinicians with various levels of experience may provide psychotropic medication. Some may have limited understanding of psychodynamic psychotherapy. Also, nonprescribing therapists, after initiating a medication consultation, may assume that the medication aspect of the treatment is being addressed and may not explore the meaning of the medication to the patient (Floeresch, 2003). The child or adolescent as well as the parents may have strong transference reactions to the prescribing psychiatrist, some of which relate to the meaning of the medication, but it is also an opportunity for projection and displacement of feelings toward the therapist onto this other clinician, a "splitting of the transference." In this article, we describe our clinical experiences as two child and adolescent psychiatrists to encourage clinicians' increased sensitivity to the signs of underlying conflict about medications.

Initiating Medication Use

Recommending medication can be understood as a dynamic intervention in the family system where the family is often in crisis or at least stressed enough to seek outside professional help (Rappaport and Chubinsky, 2000). Parents, of course, have their own conscious and unconscious resistance to their child taking medications, and their apprehension can be conveyed in many ways to their child. Usually, parents who are in the process of accepting that their child needs medication have come to a distressing recognition

of the serious nature of their child's problem. They may feel ashamed that their child is "damaged" and feel that this reflects badly on them personally or see their child's difficulties as a failure of parenting. Parents may feel guilty that they have transmitted an inherited condition to their child. They may be hopeful that the medication will help their child or overly optimistic that the medication will serve as a cure-all. They may be suspicious that their child is being unfairly forced to take medicine because of their distrust from other life experiences in which they have felt disempowered. Parents may have anger or ill wishes toward their child because of the exhausting toll of their child's behavior. Sometimes they may unconsciously punish their child by badgering him to take medication that sedates him so that he will be less troublesome to manage. Rarely they may express unconscious hostility by undermining their child's taking much-needed and effective medication. These kinds of parental reactions are often complicated by their families having had histories of mental illness and drug abuse, where the prescription of medication for a behavioral symptom ignites fears of chronic illness or an impending addiction.

Many factors affect children's and adolescents' reservations about using medications (Pruett and Martin, 2003). Children and adolescents may have doubts about the accuracy of the diagnosis and be skeptical about the role of biology in their dysfunction. Even when parents and teachers express concerns, children and adolescents may discount their symptoms and blame adults for unreasonable expectations. Taking medication may also be experienced by the child as a challenge to his or her evolving sense of self. Children and adolescents are highly sensitive about peer acceptance and therefore may have concerns about the possible social stigma associated with taking medication and worry that they are seen as crazy, bad, or stupid. They may have fears or anxiety about ingestion including pragmatic concerns such as the risks of weight gain, acne, and sexual dysfunction. They can also have difficulty discerning the difference between drug abuse and medication use, particularly when there are family members with substance abuse disorders.

Treatment Issues

Children's symptoms can be influenced by multiple sources, including biological predisposition, internal conflicts, or expression of family dynamics (Berkowitz et al., 1974). Recognizing the potential influence of several factors is particularly critical when diagnosing children's and adolescents'

symptoms that may prompt us to prescribe medication. If clinicians are compelled to provide too rapid a diagnostic evaluation and are prompted to medicate without knowing the meaning of the symptoms, there is, in our view, a risk of overprescribing. The child and family may only reveal the meaning of a symptom in the context of a therapeutic relationship. For example, an adolescent's promiscuity may turn out to be related to learning that her father was having an extramarital affair rather than interpreted as a hypomanic symptom. A teenager's excessive drinking may be seen as self-medicating a clinical depression when it has more to do with his mother's covert alcoholism.

The decision about whether to medicate can be difficult for the clinician. In our experience, it is influenced by his or her belief based on clinical experience and available research in the relative efficacy of behavioral, psychodynamic, and medication treatment. It is affected by the severity of the symptoms, the availability of the other therapies, the clinician's comfort with integrating modalities, and the resistance of the child or adolescent and family to that intervention. How long, for example, should a psychotherapist devote to determining whether a symptom is related to a chronic depression, internal conflict, or family dynamics and try to help with psychotherapy before recommending medication? This unfolding of the diagnostic process is illustrated by Eleanor, an 11-year-old who presented with increased irritability over the prior two months and depressed mood for over two years. Her parents, both professionals, divorced when she was eight years old. They came together to the office. Both described her as smart but not a star at school and as an excellent athlete but unable to stick with a sport. For example, she liked soccer but often quit when she thought the rules were unfair. As a small child, she had temper tantrums that would last hours. By the time she was 10, the tantrums had subsided, but she seemed more depressed and passive. Two attempts to engage her in treatment with psychodynamic play therapists, both prior and subsequent to the divorce, had failed. At present, her parents worried that she was isolating herself, avoiding risks, and becoming irritable when they pushed her. She seemed a little more agreeable to seeing a therapist now than she had in the past. Both parents suffered from depression and were on antidepressant medication that they viewed as helpful.

Eleanor denied being depressed when she met with the child psychiatrist. He noted that she was reluctant to smile. She nodded and said that the school counselor always said that when he passed her in the hallway at school. The therapist suggested they make smiling a goal of their work together because it was the only symptom of depression that she acknowledged. When asked

about friendships, she replied that she had some close friends in the past but now only had some "acquaintances with potential." They agreed to also try to understand why making and sustaining friendships had become difficult. The clinician considered the possibility of a trial of antidepressant medication and presented this option to the parents. Their consensus was to begin individual psychotherapy, with parent and family sessions as needed. The plan was to re-evaluate the decision about medication by assessing her engagement in therapy, changes in severity of symptoms, and the rapidity of response over the next few months.

Eleanor engaged with the therapist around computer game play. The early focus of the play was a computer game called *The Sims* that she asked to play. This is a popular game in which the player creates a family. Each member is assigned his or her own attributes, such as being neat, outgoing, or social. The family buys or builds a house that they decorate, have jobs in which they can be promoted, and try to meet the needs of all the family members. These needs include happiness, space, hygiene, social life, and food. The game varies between slightly silly aspects such as the singsong gibberish that characters speak to serious matters such as house fires in which people burn to death because they forgot to purchase a fire extinguisher. Children, like Eleanor, are often particularly interested in this game. As a child of a divorce, the creation of a family and home (some will make two) seems like an ideal vehicle for dealing in play with the traumatic aspects of these events.

Eleanor took great interest in the building, decorating, and landscaping of her house. She created a family similar to her own and concentrated on satisfying its needs. This seemed to parallel a renewed investment in peer relationships and other developmental tasks outside of therapy. She began to smile, for brief moments, when discussing events. She acknowledged this tentatively. The therapist offered that perhaps not smiling was a way of keeping other children and people away, so that they did not know how much she liked or cared about what they thought of her. Maybe lately, she was a little hopeful. Eleanor had a particular problem in the game, however: keeping her family members from getting depressed. This is usually not a difficult aspect of the game, and Eleanor would buy them things and have them do fun activities, which usually lifts their mood but, in this family, the parents' mood would inevitably drift down again. After a while, it became a sort of joke we shared about how hard it was to keep those parents from getting depressed. There was also an actual conflict between her parents during this time, and they asked the therapist to meet with them. Their old anger toward each other had resurfaced briefly, but at a time when the

therapist and Eleanor could discuss it. Perhaps, Eleanor could see that it was not her doing and that her parents could reach some accord on their own. She remembered some of the tension when they were married and considerable detail about alienating friends because she felt angry and different at that time. She recalled that it was then she had stopped smiling and didn't want to be approached. Over the next few months, her mood improved further, and she was hopeful about the future. She rekindled a number of earlier friendships in addition to forming some new ones. She also tried out for the school play and requested guitar lessons.

One formulation of this treatment is that the relationship with the therapist as well as Eleanor's insight into the effects of her parents' divorce were helpful in this recovery. It can also be that a clinical depression ran its course, and response with or without psychotherapy might have been more rapid if treatment with an antidepressant had been initiated from the outset. The factors that influenced the decision were the family's resistance to initiating medication without a trial of psychotherapy, the acceptance of a psychodynamic formulation of symptoms and treatment by the family and the clinician, and the availability and affordability of that treatment for this family. Factors that influenced the consideration of medication were the nature, severity, and duration of the depressive symptoms; the data supporting medication response; the parental history of depression and medication response; and the therapist being a child and adolescent psychiatrist, which facilitates prescribing and monitoring.

In other instances, when there is a slow or poor response to psychotherapy, a decision is made to consider medication, sometimes referred to as a medication consultation. Although this is appropriate, we believe that it should often involve a consultation regarding the overall treatment, including issues of reevaluation and formulation of the child's problem (e.g., neurological and medical workup, neuropsychological testing, psychological testing), aspects of psychotherapy (therapist–child impasse, therapist–child match, frequency of sessions), or type of therapy (psychodynamic, cognitive-behavioral, psychopharmacological, family, or group).

A Fragile Alliance

A strong alliance and evolving psychotherapeutic relationship may facilitate a child or adolescent agreeing to an appropriate trial of medication. As Meeks and Bernet (2001) remind us, however, the alliance with a teenager is particularly fragile. The treatment of Cory, an adolescent at high risk,

illustrates aspects of this dynamic process including the impact of medication. When the adolescent psychiatrist first met Cory at age 15, he had already failed two "Wilderness" programs and, like many adolescents in turmoil, was distrustful and felt any overture of support was patronizing. He was bright, artistically gifted, and a masterful storyteller. His early history was notable for having lost his father at age three to brain cancer. His mother remarried when he was five years old to an old college friend; on the surface, Cory was thriving at school, socially, and as a musical prodigy. He always exhibited a level of impulsivity, volatility, and low frustration tolerance, however, that the parents minimized. Mother reported a family history of bipolar disorder, which included her sister and which she now feared had been "passed on." Cory related that he felt more and more like all his success, even his saxophone playing, was to please them, not for his own satisfaction. In his early teens, because of what he described as a craving for stimulation, he started sneaking out to attend "rave" dances and used the drugs "E" (ecstasy) and "K" (ketamine), which are often part of that scene. When his mother and stepfather belatedly addressed his behavior and attempted to set limits, the situation became explosive, and he was sent away for treatment.

The psychiatrist attempted to engage Cory and his family in a combined or integrated treatment. Ideally, this might have included individual and family psychotherapy, medication, possibly an adolescent group, and substance abuse treatment. In this case, family sessions deteriorated into out-of-control abusive exchanges between Cory and his mother. These meetings did solidify the psychiatrist's alliance with Cory, because although the psychiatrist did not take his side, it was clear to all that it was not all "his problem." Cory's past history, family history and present symptoms pointed to disorders in regulation of attention, concentration, and mood. Cory's response to psychopharmacological intervention, however, was to adamantly reject prescribed medications as unpleasant, ineffective, and, at worst, an attempt to lobotomize him. He provocatively quoted a line from songwriter Tom Waits, "I would rather have a free bottle in front of me than a prefrontal lobotomy." For his part, Cory's psychiatrist was frustrated that Cory resisted potentially helpful interventions, including medication. Perhaps because he enjoyed the conversations or just because he feared being sent to yet another "residential" program, he readily agreed to meet with the psychiatrist twice weekly for psychotherapy.

Cory's episodic drug use was one of the more anxiety-provoking aspects of working with him. The psychiatrist focused on asking questions and maintaining curiosity about Cory's dangerous drug use and what he was

feeling before taking drugs and the effect he was hoping to feel afterward. It is a difficult balance for the clinician to express interest in the details of his exploits without encouraging them and to convey concern over the risks of the behavior without conveying disapproval of him. Cory came to recognize that in situations in which he felt incompetent or insecure, he wanted drugs to avoid feeling vulnerable. At all costs, Cory wanted to avoid the shameful experience of being desperately dependent on someone else. Over the next year of twice-weekly psychotherapy, it was this approach of exploring his drug use as efforts to self-medicate that allowed Cory to accept that he had difficulty regulating his mood and his attention span. The idea of taking stimulant and, later, mood-stabilizing medication became tolerable. It coincided with increased tolerance for his own imperfections and for his dependency on his psychiatrist.

As in psychotherapy with all adolescents, the developmental tasks articulated by Blos, including separation from parents, identity formation, social and sexual intimacy, and the capacity for work emerge in complex, interrelated ways (Blos, 1979). For adolescents with affective instability, each task is intensified and the risks seem more extreme. Each task can be a matter of life and death—figuratively and literally. Fortunately, mastery in one task often sets the stage for progress in another.

Parents, teachers, or clinicians often perceive a child's or adolescent's behavior as problematic, whereas young people may view it as fun, a way of gaining approval from their peers, or a way of expressing themselves. In psychotherapy, however, the therapist finds opportunities to raise questions or offer alternatives when the adolescent's stance is too rigid or self-defeating. If the alliance is good, the adolescent may agree to try a new strategy if there is sufficient gain and if he can avoid a loss of face. For example, when Cory found a girlfriend that he cared about, his volatility became a liability because his girlfriend was frightened by his explosiveness. This motivated him to struggle to control these behaviors. He began to see self-discipline as a desirable attribute, but one that he could not master alone. Part of a psychotherapist's role is to be poised to attend to these emerging possibilities, somewhat akin to what Winnicott referred to as "spontaneous gestures" of the patient. The therapist is in the delicate position of encouraging the patient to try medication but in a way that respects his or her emerging autonomy. This increased understanding of his problem led Cory to take medication more regularly and to try mood stabilizers to help with his volatility. He also began to think more positively about the future and to strategize about whether there was some way to utilize his energy and creativity constructively.

Not unexpectedly, setbacks were experienced, sometimes dramatically. When the relationship with his girlfriend ended, a sequence of self-destructive behavior ensued, including drinking and physical fighting. Cory was disappointed in the efforts of words, medication, and his psychiatrist. He began to miss sessions and to lie about the reasons. He was forced to deal with the rupture in the alliance when as part of his probation for a brawl, it was stipulated that he continue regularly in treatment. He had feared the therapist's reactions to his erratic behavior following the breakup and was relieved to see that the clinician was not critical. Together they tried to understand the shame and self-criticism that motivated his drinking and fighting. He compared the feelings of breaking up with his girlfriend and relying on his psychiatrist to the feelings of desperate dependency that he had experienced with his parents and attempted to avoid through his earlier drug use. The earlier psychotherapy had helped him understand this and to trust in the relationship. He thought he could trust his girlfriend, too. He had allowed himself to be vulnerable, and now he was wounded deeply. In this process of repairing the relationship with his psychiatrist and acknowledging his dependency, Cory became clinically depressed with neurovegetative symptoms. Although antidepressants relieved the acute pain and withdrawal, Cory had not previously been depressed to this degree, and it was as if he was discovering another more ominous side. He connected his rage at his girlfriend with his rages at his mother when he was younger. Their relationship had always been volatile, fueled by a deep sense of betrayal, "Like sending me to that wilderness program," he said.

One way to understand these events from a psychodynamic perspective is to view the therapist as a stand-in for a "good-enough father." He provided an opportunity for Cory to develop mechanisms for managing intense affective states, to feel more competent in dealing with the external world, and, finally, to gain confidence in his capacity to establish and maintain a relationship with a woman. Whereas early in the treatment, Cory had an unconscious fear of being abruptly abandoned, he gradually allowed and sought out his therapist's advice. He also developed a desire to please him. The breakup of his relationship with his girlfriend and the sense of betrayal, hurt, and rage overwhelmed him, however, and placed any gains in jeopardy. In retrospect, it unmasked aspects of his early traumatic relationship with his mother. As Cory became more introspective, he explored the effects of losing his father as a child. There was a great deal of sadness. He also expressed anger and disappointment in his mother's very "conditional" love and approval. Cory also revealed that his mother had often told him that his father was a thrill seeker in his adolescence. Was there identification with

his father so as to avoid losing him completely? Was it a way to please his mother by emulating his father? Was the desolation related to his loss of his adoring father or the result of his mother's unavailability after the father's death? He found himself getting closer to his stepfather. Formerly, Cory had always dismissed him as too "straight" and subservient to his mother.

As the depression lifted, Cory began to work at school for the first time since elementary school, and in a very focused way—as if to make up for lost time. He excelled in his last year at high school and attended college where he did well. He started playing music again but traded in his saxophone for a trumpet. He had a new relationship. The repair of the relationship with the therapist and the insights gained looking at the meaning of recent events in light of the past seemed helpful. As this case illustrates, the role of ongoing medication and the cognitive maturation (Piaget's formal operations) may be important factors in allowing treatment to go forward.

Side Effects

It is important to consider the possibility that medication side effects may be emerging if a child's or adolescent's behavior changes abruptly in psychotherapy. A therapeutic impasse may result. For example, Tony, a depressed adolescent with poor self-esteem, was started on an antidepressant. He initially responded dismissively to information about possible sexual side effects with "Who cares? I would never attract a girl anyway." He revealed that his perceived rejection from female peers made him constantly self-critical and inhibited. The antidepressant helped a great deal with his energy level and his mood. Less depressed, Tony was able to use his psychotherapy to talk more openly about many of his insecurities and explore the basis for them in his past and with his family. He was able to invest in his academic work and made new friends. Unexpectedly, Tony began to come late to sessions and was more reserved when he did come. The psychiatrist wondered about a possible relapse. Subsequently, in discussing the possibility of increasing the dose or changing the medication, Tony was able to acknowledge that he blamed the drug's sexual side effects and weight gain as the main problems affecting his confidence. He had even fantasized that his doctor was deliberately poisoning him. He was relieved that his psychiatrist was responsive to his concerns, acknowledged the role of the medication, and then provided other medical options.

When a child has harmful side effects from the medication that the therapist prescribed, the reactions of the therapist, family, and child need to be

explored in the context of the ongoing psychotherapy. This is more readily accomplished in a combined treatment. It should also be possible for a nonprescribing therapist, however, because the meanings of the medication and their side effects have transference aspects that will affect the relationship with all caregivers. Unpleasant side effects can range from embarrassing episodes of incontinence at a friend's sleep-over to disinhibited behavior that requires hospitalization. These events can have a very disruptive impact on the therapy: the child may develop new symptoms, the parents may withhold payment, or it can be seen within the child's play itself. For the prescribing psychiatrist, the countertransference may emerge as a wish to find a new medication right away, to avoid prescribing medication for too long, or to have someone else prescribe medication. The clinician can be self-critical that he was unable to avoid the unintended outcomes. For example, Sally, a 16-year-old who had a mother with schizophrenia, was able, with the help of her psychotherapy, to accept that she needed medication to help her focus and cope with a debilitating depression. In response to an antidepressant, she had a psychotic reaction during which she cowered in her bedroom trying to escape the devil. She needed to be hospitalized briefly. The treating psychiatrist felt terrible. Even after Sally recovered, Sally felt that her worst fear—that she would end up with schizophrenia like her mother—had come true. The clinician had to process her own disappointment so that she would be more available to process her patient's understandable confusion and sense of betrayal. With patience, this rupture in the alliance was repaired.

Conclusion

For child and adolescent psychiatrists who have the enviable opportunity in these financially restrictive times to provide both psychotherapy and medication, there is an opportunity to learn about complex interactions between them. Often children and adolescents need time to build an alliance with the clinician. This time allows for more engagement with their patients to explore the multiple meanings of their symptoms before a medication trial. For those patients, symptom reduction has the potential to foster a deeper, more effective psychotherapy. Psychotropic medication use in children and adolescents is likely to continue to grow, as will controversies surrounding that use. We need to continue to examine psychotropic medications and their impact on symptoms, but we must also reflect on medication's effects on the meaning of symptoms, on theories of causation, and on the child's

relationships with parents, school, and self. We have explored the impact of medication on the alliance of the clinician and his child or adolescent patient, on transference and countertransference, and on aspects of the psychotherapy process. The psychodynamic aspects of these interactions are evident regardless of whether we are the clinicians providing the other treatments. We believe that our patients are better served by multimodal approaches if we are trying to integrate them. This requires us to explore their impact on each other and on the entire system. Such an approach offers the potential to help preserve fragile alliances and expand the range of children and adolescents that we can help.

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