On My Mind: The psychology behind taking medication

I take my blood pressure medication every day. It works. Not only does it feel good when I see my blood pressure where it should be, but also, I've realized, I like taking medication. My father was a doctor, and his best friend was our family pediatrician. When I was sick, they were attentive and caring; the pills they prescribed made the world seem safe and good. Furthermore, I feel that my primary care doctor knows me, cares about me, and treats me kindly. I trust her recommendations, and like to follow them.

If, instead, a person's early experiences of authority figures and caretakers were characterized by cruelty, boundary violations, and inconsistency, perhaps it would not be so easy to swallow a prescription. Different people respond extremely differently to the same medications and other substances. To begin with, 20 to 30 percent of people never fill their prescriptions. Fifty percent don't take them as prescribed. It turns out that a large component of what makes a medication effective or ineffective is how a person feels about taking it. In fact, studies of

antidepressants show that over 75 percent of their effectiveness is attributable to the placebo effect.

It has long been known that placebos (harmless pills that are inert — have no direct chemical effect) can reduce anxiety, irritable bowel syndrome, and high blood pressure among many other symptoms. But doctors don't prescribe them because it is regarded as ethically wrong to tell a patient that they are receiving active medication when they are not. Nevertheless, studies have shown that when people are told with "radical honesty" that they are being given a placebo, and treated with the rituals of a good doctor's visit, that they actually have a real response (see bit.ly/HonestPlacebo).

In one study of 112 patients with depression, the most successful one-third of prescribers saw more response with placebo than the bottom one-third had with active medication. Medication worked in both groups, but placebo was more powerful in the hands of the top prescribers than active medication was in the hands of the less successful prescribers. Who was prescribing the medication was a more important factor of recovery than the medication itself. (See ncbi.nlm.nih.gov/pubmed/16503356.) Similarly, in a study of panic disorder and benzodiazepines (medications like Valium, Xanax, and Klonopin), placebo was more effective in highly motivated subjects than active medication was in unmotivated subjects. (See ncbi.nlm.nih.gov/pubmed/9160550.)

David Mintz, M.D., of the Austen Riggs Center points out that despite all of the new psychiatric medications, there has been no substantial improvement in medication outcome for decades. He hypothesizes that one reason might be that clinicians are more and more focused on quick diagnosis and prescription writing than on thinking about symptoms in a psychological or psychodynamic fashion — a methodology known as "psychodynamic psychopharmacology." According to Dr. Mintz, "it is an approach to pharmacotherapy that explicitly acknowledges the central role of meaning and interpersonal factors in promoting good treatment outcomes."

If I have a good alliance with a patient, the medication I prescribe is more likely to be taken, and if it is taken, it is more likely to work. Given that early trauma is such a strong predictor of physical and mental illness later in life, clinicians work with many people who have survived mistreatment by their caregivers. (See bit.ly/SelfSoothe.) It makes sense that those people would be wary of caregivers, and especially doctors who prescribe powerful medications intended to change the nature of how their brains and bodies operate.

When it comes to prescribing medication, I find the Internal Family Systems Therapy (IFS) model particularly useful. IFS posits that we are not unitary beings, but rather that our psyches are a composite of subpersonalities, as is cleverly depicted in the animated film “Inside Out”. (For more on IFS, see my article, bit.ly/MVTreIFS.)

I know that when someone comes into my office, a part of them wants to feel better and wants my help getting there. But other parts may not.
A prominent IFS psychiatrist, Dr. Frank Anderson, says he will not prescribe medication unless all of a person’s parts are in agreement about taking it. Even if someone sounds ready to take a medication, they might also be thinking, What about the side effects? Who will I be without my anxiety or depression or hallucinations? Will it cause weight gain, or change my sex drive? Are there long-term side effects that are not yet known? Will it numb me, and interfere with my ability to face my problems head-on? And if there is a way that a person is trying to numb themselves from the pain, how is it going to sit with that numbing protective part if a medication wakes them up and makes them more present? Dr. Anderson would suggest that that part might interfere with the medication by inducing unpleasant side effects. Seeking out the voice of doubt offers the opportunity to calm that voice and help the person seeking help (and me) to understand and rationally weigh the risks and benefits of a medication.

Some people who have been abused or frightened in the past are on guard, and vigilantly trying to protect themselves from more harm — even if there is no conscious memory of abuse. When frightened, parts of our personality can and will “push the biological button,” as Dick Schwartz, Ph.D. and IFS founder, calls it. Think of the expression when seeing something horrific, “this is nauseating”; when onerously challenged, “what a headache”; when frightened, “I am shocked.” These are all descriptions of physical reactions to what is happening to a person psychologically. Similarly, the body reacts to psychological responses that arise when a person takes a medication, which is why placebos can appear to have side effects, and may partly explain why active medications sometimes have no effect.

While it is true that wary parts of our personality can press the biological button, Frank Anderson points out that it is also true that physical side effects press the emotional button. There are inevitably parts of ourselves that are rightly dismayed when medication causes weight gain, removes sexual drive, makes us unable to cry, or leads to fatigue or mental slowing. If these side effects are left unaddressed, people will often stop taking needed medication.

Trauma survivors often have physical symptoms that are actually ways in which the body remembers trauma — sometimes even in the absence of conscious memories. (See the groundbreaking book by Bessel van der Kolk, "The Body Keeps the Score: Brain, Mind, and Body in the Healing of Trauma.") For these people, because medication will change their bodies, it needs to be used with special caution.

Everyone who sees a doctor needs to be treated with kindness, dignity, honesty, and respect. The parts of people that are trying to protect them from harm deserve specific appreciation before they can relax and get on board with treatment. There are a few rules that I try to follow when prescribing medication.

I try to avoid the notion of a mind/body split. It is an illusion. Feelings are created by the brain and change the brain, and the brain changes the body. As David Mintz points out, William Osler, the 19th century father of modern medicine, said, "It is much more important to know what sort of patient has a disease than to know what disease a patient has." And I try to attend to ways in which taking medication feels dangerous to a patient. (Medication may lead to side effects, loss of one's sense of identity, prohibition of usual sources of comfort like alcohol or other tools of self-soothing, or fear of the prescriber. And blocking appropriate feelings may impede an individual's opportunity to work it through.) It is essential to seek and address concerns and doubts repeatedly through treatment. As a prescriber, it is tempting to want to push on a treatment approach that I have seen work for other people. I need to remind myself to leave my agenda behind in favor of the patient's. As Frank Anderson says, "I educate, you decide."

Especially for people who are frightened of taking medication, it is often a good idea to start with very low doses, choose a medication that is least likely to have side effects, incorporate behavioral interventions (like diet and exercise) or alternative treatments (see bit.ly/MVTalternatives), and/or use medications that can be taken on an as-needed basis. Such strategies can make all the difference in reassuring those vigilant voices within us.

Shankar Vedantam, NPR science correspondent and host of "The Hidden Brain," points out, "When we go to a doctor, we need two different things. The first is explicit and obvious — we want someone skilled and knowledgeable who can diagnose us correctly, who knows which pills or procedures are likely to help. But we also have implicit needs. We want someone who can attend to our suffering, not just to our illness. We need someone to trust in moments of fear and

vulnerability. We want more than answers; we want reassurance … Our explicit needs can feel more urgent than our implicit needs. Surgeries and medications can seem more rigorous than the techniques to address our implicit needs — acting and storytelling and rituals. On top of that, these elements of performance may feel unseemly, like the behavior of snake oil salesmen. But when both kinds of needs are met, doctors and patients are more likely to get the outcome they both want — healing."

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