Pharmacotinamid and Psychodinamic

in the neurosis: their mutual relationship.

1)

Pharmacodynamics and Psychodinamic in the neurosis: Her mutual relationship-

by I. Lopin-Ihor

The introduction of the psychopharmacology of neuroses obliges us to set up new problems in its psychodynamics. For some years it has been a dangerous affair to talk of neurotic disturbances which were not psychotherapeutic, and even today there is a resistance towards thinking of the beneficial action of certain drugs. Previously, one only took into account the possible symptomatic treatment by a medication; eg., a tranquilizer in order to sleep or a vegetative sedative for nausea. In general the action was negative.

Freud's dream, however, was to discover the organic basis of neurotic symptoms. Even in the last writings published after his death he vigorously insists on this conviction, assuring that the future will bring "means to influence directly the burden and distribution of energy from the psychic apparatus, especially through chemical substances. Perhaps other therapeutic possibilities will be discovered: for the moment we have at our disposal only the psychoanalytic technique, but we must not shun from thinking of its limitation." There still remain many enigmas of Freud's personality and intellectual world which Jones's biography has not clarified (including the ones he proposed to clarify).

This ambiguity of Freud is very indicative: on the one hand, he worked arduously not only to elaborate the psychoanalytical doctrine, but to see that it would be adopted as dogma, and on the other hand, he admitted its provisional validity, until other methods would be discovered for acting upon the disturbances of nervous energy. The fact is that, in spite of what this discovery made clear, psychotherapy will one day be not only a means of action on neurotics, but on all patients in general; and it is valid to recognize that psychoanalysis has been a restriction to therapeutic possibilities. As Buhler said years ago, Freud has always been a "Stoffdenker."

Despite Freud's prediction, he usually considered the administration of drugs as a violation of the rules of psychoanalytic treatment. The problem is connected to another one of secondary character, but of no less importance: the existence of depth analysis and, in general, of depth psychotherapy. According to legislation in almost all countries, only medical doctors are authorized to administer drugs, although in reality the world of amateurs to recommend them coincides with almost the whole world of mortals. The depth analyst or the psychologist, not being a doctor, cannot administer a drug without entering into conflict with the law.

The refusal of psychoanalysts to administer drugs, results from the assertion that they clog transference. One could

3/

discuss this point at length. In any case, the truth is that they do provoke a disturbance of psychoanalytic transférence, in a restricted sense. The basis of transférence lies in the metamórphosis of interpersonal relations in "transférence neurosis." This supposes a displacement of the adhesive cloud of anxiety; but the cloud maintains its density and even increases momentárily through an evocation of the crisis: episodes and anxiety-provoking phases from the previous life of the subject. Moreover, this mobilization of anxiety brings about plentiful material from anxious dreaming. The psychoanalyst encounters direct and transferential contact with the patient, as well as abundant interpretative material. The cure, when it is psychotherapy, advances with the puffed-out sails of this wind of anxiety, formed and directed like air currents produced by the rotation of airplane propellers.

If, in some phase, an auxiliary drug diminishes the intensity of anxiety, it produces a real deflation of transférence; but not only that, the transference changes its style and mode. We could underline this change by saying that the transference was more medical and less psychoanalytical. Still, at the basis of transférence we always have the same structure; its mode of establishing itself is distinct. In psychoanalytic transference the revisionist and anamnestic character of experience is accentuated, so much in some works that it begins to signify a prospective character. In Jung the arche-

typal character of the self is emphasized: the doctor with magic. The secret of transference is the dissolution of anxiety. It is not the same if it dissolves by a drug or by interpretation. Obviously, the presence of the doctor always has its own effect, and the addition of a drug augments his efficacy only if a transference relation was previously established with his patient. It is not a transference relation, but a transference neurosis.

In spite of these obstacles, pharmatherapeutics has gained ground. In the Buenos Aires Symposium on the treatment of depressions (1960) the use of drugs was recommended to qualified psychiatrists against depression and anxiety. Benedetti says that when the psychotherapist finds himself faced by acute symptoms in a young personality desperate for aid, he must not reject sedation which would increase the patient's confidence in the doctor and facilitate the work; but when the psychotherapist directs himself to less dramatic cases of a chronic nature in a person who shows comprehension of the situation, the psychotherapist must abstain from all sedation of the "fecund" anxiety which must be allowed to flow in order to enrich the psychotherapeutic work. When a patient is burdened by physical symptoms, administration of a drug, if only of a suggestive nature, will permit the doctor to establish contact and to penetrate little by little into his problematic psyche. On the other hand, in certain phases of

depth psychotherapy, the drug may impede the irruption of disturbances which mobilize the play of transference and resistance and facilitate the progress of depth analysis.

In general, the reproach which is made towards pharmotherapy from a psychotherapeutic point of view, is that it masks or conceals the conflicts. The patient finds himself relieved, but, it is said, he deceives himself. This concealment of the disturbances impedes depth analysis of the conflicting trauma. In the face of this reproach it is necessary to reaffirm that if neuroses are only abnormal psychic reactions, situations of conflict present or past, badly directed by the personality, etc., etc., this attitude of psychotherapists is justified. Moreover, if the medications have no more action than as sedatives, even greater is the justification. On the other hand, if neuroses are alterations in the state of the self, jolting, brief or permanent, in the endothymic basis of the personality, disturbances of the vital emotions, disturbances of the "vital tone," etc., etc., then the application of pharmotherapy is amply justified and the attitudes of psychotherapists must be changed. (Even an author like Sarro, who maintains his adhesion to the purely psychodynamic interpretation of neuroses, demands a change in the psychotherapeutic postulates, precisely because the new pharmocology has placed before us new facts.) It is no longer a question of drugs whose action on anxiety is peripheral, that

is to say, limited to diminishing its neurovegetative expression, but drugs which have direct and central action on the anxiety.

The vital or endothymic basis of neurosis can be likened to that of the depressions. When I formulated this analogy in my book on "The Vital Anxiety," I extracted from it a therapeutic consequence. If depressions are treated with electroshock---as they were between 1943 and 1950---it is natural that neuroses should be treated by an analogous method. The result of electroshock was inappropriate; nevertheless some psychiatrists used it until hysteric patients showed its inadequacy by the disproportion between the violence of the therapeutic attack and the disturbance which was to be treated. Fiamberti proposed acetilcoline shocks in treating schizophrenia, and for this reason it was thought possible to utilize the same type of shock, but of a weaker nature, in the treatment of neuroses.

The possibility of medical action on the vital nucleus of neuroses has made it necessary to study the modalities of the self. The lines of pharmacological investigation are immense. Until now neuropharmacology demonstrated its products on animals, which were the foundation of pharmacological tests having little in common with clinical reality. This was the first step of investigation. On the other hand, the works of clinical statisticians are insufficient, although they are

indispensable and constitute a guide in the use of medication. What is now lacking is the intermediary stretch consisting in a prolonged and careful analysis of the medication's action in each individual case, according to the phenomenology of the endothymic disturbances which constitute it, and according to the repercussions on the more personal levels.

Taking into account the danger of any scheme, for the best comprehension of the psychic facts, we might say that there exists two levels in depression: one which consists in an alteration of vital emotions (sadness, anxiety) and another of the psychic emotions (guilt, ruin). This stratification of symptoms is artificial, but it brings to light an important fact: experiencially considered, some symptoms exist further from the vital level than others. Some of the separated ones come to form the depressions without depression. This devitalization, this vital uprooting of the symptoms is important when one is trying to obtain the isolation of symptoms accessible to therapy. We might formulate a general rule: In proportion as the psychopathological picture appears more devitalized, the accessibility to therapy is lessened.

These differences are more apparent with the new drugs than with electroshock and they serve as an understanding, at least hypothetically, of the differences in action between both medications. Electroshock effects violent assault on the regulatory mechanics of the diencephalon, and it is capable of changing these regulations of character. In contrast, the

new drugs liberate the patient from his depression without changing the rythm of his vitality. What is observed in treatment with these drugs is a lessening in the intensity of depressive symptoms almost to the point of disappearance. The patient submitting to this treatment is alleviated partially or entirely from the tremendous discomfort which depressive symptoms produce. For this reason also, if high doses of medication are continued, the appearance of secondary symptoms (vertigo, paresthesis, etc.)from the medicine becomes more frequent as the patient recovers. A good rule is to diminish the medication when the symptoms appear, excepting, naturally, those cases in which they appear prematurely.

Analysis of the greater or lesser vital roots of symptoms pertaining to the level of psychic emotions is often difficult. Above all, the distinction in levels is a scheme and the clinical reality offers a fusion of both planes. It is simply a question of discriminating the greater or lesser degree of fusion of the vital and psychic emotions in each case. Actually, there are ideas of guilt which emanate very directly from the level of vital emotions. At other times, from a vital point of view, they are totally uprooted. In the first case, the success of the new drugs is almost certain. In the second, it is more problematical. It is a question of <u>interior distance</u> between both symptomatological planes, interior distance which the psychiatrist can perceive by a

careful analysis of the way in which the patient expresses his interiority, and by the appraisal in conjunction with his clinical picture, not only horizontally but also vertically. The same principle holds for the basic symptoms of depression: the more vital the sadness or anxiety, the more easily is it treated by pharmacological means.

In neurotic depressions the same picture can be seen. Volkel recognizes that in vitalized neurotic depressions one often observes an elevation of the "biotone" during the agitating treatment. Obviously it is not the same thing to speak of the biotone as of the vital emotions. Vital emotions are a psychological and psychopathological reality; the "biotone" is a clinical hypothesis. Depressions are characterized by the presence of a vital sadness in addition to other symptoms and suppositions which accompany a depression of the vital tone or "biotone."

In summary: it is necessary to treat neuroses like personal illnesses. The adequate treatment is psychotherapy. There are many therapeutic directions; but as varied as they may be, more varied still are the personalities of the neurotics. At bottom, all psychotherapy is transference and, to my way of seeing it, is nothing else than the dissolution of anxiety which the doctor exercises by his human presence. In the crisis of anxiety the patient no longer knows where he can "hold on." His relations with the world are dissolving; the

doctor, if only by his presence, can absorb the anxiety. But there are many ways of being present in such a situation: and the technique of being present is called psychotherapy.

But if there is also a physiodynamic part of neuroses, as I have tried to show, it is natural to think of pharmacological action. The presently available medicines permit more direct therapeutic attacks than was possible with previous medication which aimed only at the symptomatology.

For almost thirty years I have been using vegetative shocks with acetilcoline administered intravenously. The idea initially stemmed from the analogy between depression and neuroses as illnesses of the ~~self~~ mood. In the same way that in former times pharmacological and electrical treatments were utilized, I thought of the use of other newer forms, like vegetative shock, in neuroses.

Neuropharmaceutical progress has permitted a considerable reduction in the indications of electroshock in melancolia through the use of certain medicines (impramine, monaminoxide inhibitors). These can be used in lesser quantities with neurotics. Recently diazepoxid and similar medications have opened new perspectives.

Neuroses are illnesses in which the essence of the individual manifests itself. They are the most human of the illnesses and because of this the doctor must exercise an

attitude of deep human understanding. The anxiety of the neurotic must be absorbed by the doctor. It is a heavy weight, but it is one which dignifies him. To know how to behave towards anxiety is an essential task of the doctor. One can never be a good doctor without being sensible to the patient's anxiety, whatever his bodily disturbances might be. ~~These differences in sensibility are what separate the "Artz" from the "Mediziner."~~