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ARTICLE

Will this tablet make me happy again? The contribution of relational prescribing in providing a pragmatic and psychodynamic framework for prescribers

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SUMMARY

We describe the importance of relational factors in prescribing practices and discuss how they may influence treatment outcomes. Although relational factors play a part in every clinician–patient interaction, they are particularly relevant when managing patients with complex emotional needs. We discuss how relational prescribing can add value when incorporated into standard practice. We introduce psychodynamic theory principles, and we suggest a framework to facilitate reflection and support decision-making when clinicians are faced with complex prescribing decisions.

LEARNING OBJECTIVES

After reading this article you will be able to:

- identify non-pharmacological factors that affect prescribing outcomes
- reflect on relational factors pertaining to patient and clinician characteristics and, importantly, the patient–clinician relationship
- use a relational framework to help guide decision-making when faced with complex prescribing dilemmas.

KEYWORDS

Relational; prescribing; transference; countertransference; psychodynamic.

Despite advances in pharmacological treatment and frequently updated evidence and guidelines, clinicians are routinely faced with prescribing dilemmas for patients who do not respond or partially respond to treatment. In psychiatry, such difficulties are commonly evident in – although not restricted to – the management of patients meeting criteria for the diagnosis of personality disorder or complex trauma (National Institute for Health and Care Excellence 2009), where clinicians might resort to polypharmacy despite lack of clear evidence for its efficacy (Prescribing Observatory for Mental Health 2012). Patients with personality disorder often bring their core relational difficulties to the consultation in ways that need to be understood and managed within the relationship with the clinician. Prescribing dilemmas are also often encountered in many other areas of medicine, such as geriatric medicine and primary care, where there is a body of research on prescribing antibiotics under pressure (Stivers 2007).

Medicine-taking is a complex human behaviour. There is growing evidence that non-pharmacological factors play an active role in treatment outcomes (Mintz 2012). For example, a well-known factor is the placebo and nocebo effect, where a patient's expectations of treatment significantly determine how they will experience the intervention. In psychiatry, the dominance, in recent decades, of the biomedical model, with the increasing advances in neuroscience and psychopharmacology, often meant that a whole body of research on psychosocial aspects of mental distress and its treatment was overlooked and neglected. However, in the context of problematic aspects of treatment resistance, there have been in the USA over the past 40 years attempts to reintroduce a more psychodynamic approach to psychiatry (Gabbard 1990; Kandel 1999). In the UK, under the influence of the work of Balint and the object relations school (Box 1), doctors and psychiatrists have been increasingly encouraged to focus on the patient–clinician dyad and make use of the therapeutic relationship as a healing agent. Balint groups are now well established in medical schools and psychiatric schemes.

In this article we are revisiting the relational factors that influence prescribing. By 'relational' we mean external relationships, i.e. the clinician–

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patient interaction, as well as internal relationships, i.e. relational templates in the mind of the patient and the clinician. A relational framework supports a 'whole person and whole life' perspective on human distress and addresses problems related to fragmentation of care (Haigh 2019). We present a few complex prescribing vignettes and use a theoretical framework informed by attachment (Box 2) and psychodynamic theory (Box 3) to facilitate reflection and support decision-making. Our fictitious case vignettes reflect an amalgam of real-life interactions and their outcomes. They also aim to convey that a relational approach is a process taking place over time and can sometimes be resisted by either the clinician or the patient, or commonly both.

Case vignette 1

Mr Z is a 49-year-old man who has experienced debilitating depression and anxiety for the past 2 years. His symptoms started after his marriage broke down following an affair. Not long after that he also quit his job following an argument with his manager. He has become increasingly isolated and struggles to look after himself. Mr Z has been seeing Dr D, an experienced psychiatrist. He has been prescribed several antidepressants, all of which he discontinued because of either limited benefit or intolerable side-effects. Dr D has approached this as treatment-resistant depression and tried some combinations of medications, following relevant guidelines, without much success. Dr D is aware that Mr Z's mother was depressed for long periods during his childhood, and his father rather absent. Dr D has been feeling very sympathetic towards Mr Z and concerned about his decline in functioning. He has tried hard to find a pharmacological approach that would be helpful for Mr Z, who seems to remain committed to seeing him. Dr D feels increasingly hopeless and inadequate in the face of successive treatment failures.

BOX 1 Balint and the object relations school

Michael Balint was a Hungarian psychoanalyst. He and his wife Enid set up seminars for general practitioners in the 1950s. These groups are now known as Balint groups. The groups offered a space for clinicians to reflect on their practice by focusing on the doctor–patient relationship. The groups promoted 'good listening', the role of empathy and the psychotherapeutic aspects of medicine.

Balint's theories come under the umbrella of the 'object relations' school, a broad term that encompasses psychoanalytic theories focusing on the importance of relationships in human development. The term 'object' refers to internal representations of external relationships. Object relations theory emphasises the influence of early experiences of caregivers that are internalised and stay alive in the mind of the person, affecting their present way of relating to themselves and others. An example would be an adult who experienced abuse and neglect as a child and is expecting similar behaviours of abuse and neglect from others as well as relating to themselves in abusive and neglectful ways (because they have internalised an abusive and neglectful object)

BOX 2 Attachment

Attachment theory places relationships at the centre of human behaviour and survival from the very beginning of life.

Attachment behaviour refers to the process of proximity-seeking to an 'attachment figure', usually a caregiver.

Secure attachment develops within responsive and consistent experiences of care. Insecure attachment is usually linked with less than good enough, neglectful or traumatic environments. It is, however, important to note that attachment behaviour is also genetically influenced.

Case vignette 2

Ms H is a 37-year-old woman from Spain. She has a good job, working as a data analyst. She has been on an antidepressant started in Spain, which is unlicensed in the UK. She has tried several antidepressants in the past and because the unlicensed antidepressant has been helpful, Dr G, her current psychiatrist, continued it. Ms H now feels her medication isn't working well enough and needs to be combined with another antidepressant to help with her depression and anxiety symptoms. Her sister had been on the combination of medications and Ms H thinks it used to be helpful for her sister. She asks Dr G to prescribe the combined regime. Dr G, feeling under some pressure and confronted with this new inefficacy of her previous treatment, agrees to try this combination, although not entirely convinced about its appropriateness. Very limited progress is made in the next few months. Ms H struggles a great deal in her relationships, worries she pushes people away and feels highly sensitive to any conflict. Her sister has autism and complex mental health problems. Her sister has also recently come to live in the UK and has been held under the Mental Health Act on a long-stay rehabilitation ward. Despite Ms H trying to help her sister, the relationship has become acrimonious and they have ceased all communication. She confides that this has been extremely difficult and brought up feelings from when she was a child. She would return home from school to find her sister on the balcony threatening to jump and would pull her back from the ledge. Her parents are absent from the story.

Relational prescribing – theory

In our conceptualisation of relational prescribing, we consider three factors – the patient, the clinician and prescribing within the clinician–patient relationship.

The patient factor

'It is much more important to know what sort of a patient has a disease than to know what sort of a

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BOX 3 Some concepts of psychodynamic theory

Acting out is a defence mechanism to describe behaviour that is used to avoid the experience of intolerable feelings. In the prescribing setting, the clinician might resort to prescribing to avoid getting in touch with their own feelings of intolerable helplessness.

Containment is a term that refers to the function of a relationship or environment that helps a person manage their thoughts and feelings. Patients might feel contained within a safe professional relationship. A clinician might feel contained within a team or organisation.

Countertransference means the clinician's feelings towards the patient, which might include two components: (a) the clinician's transference (see below) to the patient and (b) the clinician's emotional response to specific aspects of the patient's way of relating to the clinician.

Negative therapeutic reaction is a psychoanalytic term describing instances when the patient's symptoms get worse in response to emotional contact with the therapist and progress in therapy.

Projective identification is a defence mechanism whereby unwanted thoughts and feelings in the patient are projected on to the clinician, who identifies with the projection and therefore experiences something close to what the patient wishes to get rid of. For example, unwanted feelings of helplessness in the patient are felt by the clinician and less consciously so by the patient.

Transference refers to how a patient might experience a relationship in the present (e.g. their relationship with the prescriber) based on past internal working models of relating (e.g. to a parient).

disease a patient has' (attributed to Sir William Osler, cited in John 2013)

Box 4 lists several patient factors that have been shown to affect pharmacological outcomes. Patients have varying underlying beliefs and expectations about their symptoms and treatment. Some of these beliefs might be easily articulated, whereas others might be rather inaccessible and need exploration. The placebo and nocebo responses and their relationship to beliefs and expectations are well researched (Jacovljevic 2014). A patient with a depressive disorder and an anxious preoccupied attachment style might require a lot of reassurance. It is important to understand their communication in the context of their attachment behaviour (Box 2) and be aware that they, anxiously anticipating potential harm, may be more prone to experiencing side-effects (Bingel 2014). Another patient with a history of disrupted attachments and repeated trauma may find it difficult to establish basic trust in their prescriber and reject attempts to help them. Patients with a low sense of autonomy and an external locus of control tend to respond less well to antidepressants because they may struggle to find a sense of agency in their recovery (Mintz 2012).

BOX 4 Patient factors affecting pharmacological outcomes

- Beliefs (personal and cultural)
- Expectations (placebo and nocebo effects)
- Attachment style
- Personality type
- Previous experience of drug treatment (personal or by proxy)
- Medication preference
- Adherence to medication
- Readiness to change – ambivalence

(After Mintz 2012)

An important factor affecting outcomes is the patient's readiness to change and their (unconscious) ambivalence about loss of their symptoms. A psychodynamic framework can help the clinician bear in mind symptoms as not only causing distress, but also having an adaptive function. For example, a delusional belief might protect from painful reality; depressive ruminations might protect from awareness of frightening rage. The patient may reach out for help and at the same time resist change in order to maintain the psychological benefits their symptoms provide. Psychological interventions might be available to address such conflicts, but a shared biopsychosocial formulation needs to be understood by the whole multidisciplinary team, including the prescriber, as very frequently such conflicts influence prescribing.

Case vignette 1 – continued

Mr Z might well have some degree of biological predisposition to treatment resistance. However, despite his wish to feel better, his treatment resistance might also be driven by an unconscious investment in maintaining the status quo of his relationship with Dr D, which provides him with a sense of feeling cared for, unlike his childhood relationship with his neglectful parents. He may also be punishing himself from an unconscious sense of guilt for damaging his marriage. When Mr Z requested yet another medication change, Dr D decided to openly discuss his limitations in finding Mr Z the right medication but acknowledged that they have developed an important relationship over some time.

Over the course of subsequent consultations, Mr Z was able to tentatively reflect on his attachment to Dr D, tacitly acknowledging his belief that receiving a medication prescription was evidence that Dr D listened to and cared for him. He went on to express

his anxiety that he would be left without this supportive relationship once he felt better. Mr Z gradually became more able to think about the future and acknowledge some modest improvement on the medication he had already been taking. Mr Z also became curious about the possibility of having psychological therapy to make some sense of his marriage break-up.

The clinician's attitudes/responses

It is not just knowledge and competence that determine clinical decision-making (Scott 2009). There are a number of other clinician-related factors that determine how quickly the doctor reaches out for their prescribing pad. Prescribing under pressure is an important topic in social pharmacology (Delga 2003). In a primary care study on benzodiazepine prescribing, high prescribers of benzodiazepines believed that a prescription saved consultation time (Cormack 1992). Psychiatrists might resort to prescribing to manage feelings of helplessness and inadequacy if they cannot relieve symptoms in patients with personality disorder (Martean 2014). In a seminal paper, Thomas Main refers to the prescription of a sedative 'when the nurse had reached the limit of her human resources and was no longer able to stand the patient's problems without anxiety, impatience, guilt, anger or despair' (Main 1957). In the same paper he references the clinician's refusal to accept 'therapeutic defeat', leading to 'therapeutic mania' and 'desperate treatments' that place the patient in more danger (polypharmacy being one of them).

Case vignette 2 – continued

Dr G is asked to take a concrete, reductionist approach to Ms H's complicated relationship with her family and sister by trying to solve her problems with the addition of another medication. However, Ms H continues to feel uncontained by the treatment she receives. Ms H may feel guilty for not being able to save her sister from a miserable life. Ms H's request to be prescribed the combination of medications her sister had been taking may be her way of identifying with her sister and communicating her own distress and a plea to be also attended to. Ms H's continuing pursuit of a better treatment is perhaps a wish for the 'good mother' who can just make the distress go away. It is natural then for Dr G to feel she needs to make up for what Ms H has not had or to try to provide a solution by prescribing. Dr G decided to reflect with Ms H on their attempts to find better treatment and wondered whether the need to 'get it right' is something of Ms H's past experience. Ms H acknowledged that she has always felt under pressure to get it right for her sister but could not see the relevance of this to her medication requests. She let Dr G know that she found her comment intrusive and felt invalidated by it. She decided to ask for a change of psychiatrist.

Dr G was left feeling guilty, concerned that she had overstepped a boundary and eventually failed to help the patient. In her supervision group, she reflected that perhaps Ms H felt threatened by Dr G's attempt to explore the meaning of medication and wondered how else they could have approached the prescribing dilemma. The supervision group established that it was not so much the formulation of the patient's difficulty that was 'at fault' – indeed, it seemed accurate – it was more the tone and speed with which Dr G had made the formulation – Dr G had felt under great pressure to find the 'perfect' treatment. This indicates the technical skill necessary in the doctor's response – the need to empathise with the 'wish for perfection' being projected on to her, to identify her own tendency to want to provide 'perfect care', and to process all these aspects of the countertransference before making a response to her patient. The patient's response to the doctor, finding it intrusive and invalidating, may also be due to the 'negative therapeutic reaction' (Box 3), namely an exacerbation of the patient's symptoms (I want another perfect psychiatrist) in response to an accurate interpretation.

Box 5 lists some of Dr G's underlying beliefs and motivations that might contribute to prescribing decisions in response to Ms H's distress and requests. It is important for prescribers to reflect on their underlying motivations and their expectations of the care they provide.

In addition, there are often systemic and contextual factors that exert enormous pressure on clinicians to prescribe (Box 6).

Prescribing within the clinician–patient relationship

'By far the most frequently used drug in general practice was the doctor himself, i.e. it was not only the bottle of medicine or the box of pills that mattered, but the way the doctor gave them to his patient – in fact the whole atmosphere in which the drug was given and taken' (Balint 1955: p. 683)

We somewhat artificially separated the first two factors (patient and clinician) before introducing the third factor, which includes everything that pertains to the clinician–patient relationship, the importance of which is eloquently articulated in Michael Balint's quotation above. Box 3 introduces

BOX 5 Clinician beliefs and motivations underpinning prescribing

- We care for our patients and we want to see them get better
- Prescribing is what we trained to do and there is an expectation that we do it
- We need to prove our worth and we take it as personal failure if the patient does not improve
- We do not like feeling helpless or guilty
- We feel the need to 'do' something

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BOX 6 Systemic factors that pressure clinicians when prescribing

- Anxiety when managing patients who experience acute distress or are in crisis
- Expectation from others (patients, other professionals and the public) that the doctor/prescriber prescribes in clinic (in new ways of working, often this is the reason for a referral to the prescriber)
- Tension related to applying single-condition guidelines to patients with multiple illnesses and complex needs
- Fragmentation of the healthcare system
- Workload and time pressures, with little opportunity for discussion or reflection
- Conflict between clinical and managerial roles (pressure to prioritise targets over clinical need)
- Medicalisation of human distress
- Mind–body split

some psychodynamic terms that are useful in thinking about relational prescribing.

The prescribing exchange culminates in the prescriber signing the prescription and the patient obtaining and consuming the tablets. This end result is a concrete manifestation of a complex relationship between the clinician and the patient (and how they both internalise care). Patients present to services seeking relief of their distress in times of great dependence and need. Containment or failure of containment takes place within attachment relationships. The prescriber can hold powerful attributes in the mind of the patient as they come to represent aspects of earlier attachment figures (Adshead 1998) that helped or failed (to contain) the patient. The transference then might colour the patient's expectations of what the medication will do and how it might work for them. The prescriber will also experience emotions in relation to prescribing that might be part of their countertransference response, pertaining to both their own experiences, belief systems and wishes and what the patient is 'transferring' on to them. Such feelings may affect what the prescriber does and how. They might prescribe because they want to rescue their patient, out of frustration, anger or an unconscious sense of guilt, or to finish the consultation quickly.

In case vignette 1, Dr D might see himself as fundamentally helpful, caring and effective, but alongside his caring and compassionate feelings, he might experience intense anger, frustration and helplessness at not finding a solution for his patient. If he is not aware of his increasing frustration, and possibly the guilt associated with it, he might act it out by resorting to overprescribing or repeated medication changes to defend against these feelings. Dr D, feeling increasingly hopeless, decided to discuss Mr Z's presentation with his peer group. A colleague comments that Mr Z seemed to be unwilling to get better. Dr D initially felt frustrated, thinking that his colleague was blaming his patient for his lack of progress. However, his frustration was replaced by curiosity about his colleague's comment and his own strong wish to be helpful. He started considering why Mr Z could possibly 'not want' to improve. This enabled him to have an honest conversation with Mr Z about the limitations of his interventions and the importance of their relationship.

Prescribing can also happen in response to projective identification. In case vignette 2, what may be projected on to the clinician is Ms H's quest to rescue her sister and the hopelessness and guilt for failing to do so. By overprescribing or prescribing against her better clinical judgement, Dr G might be similarly trying to provide care and find a solution but 'failing', much in the same way as Ms H failed to cure her sister. In a seminal 1974 paper, Maltsberger warns against omnipotent attitudes and unrealistic expectations:

> 'To the extent that the therapist is infected with lingering omnipotent attitudes, he will mistake the patient's wishes for realistic expectations and vainly imagine he has the obligation and the power to meet them. This, of course, he will be unable to do, and will before long find himself feeling helpless, guilty, and wishing himself far from his patient' (Maltsberger 1974).

Prescribing introduces a very intimate contract between the patient and the clinician akin (on an unconscious level) to the symbiotic relationship between a nursing primary caregiver and an infant. The medication is swallowed up and metabolised within the patient's system and has the capacity to transform from within. What is ingested can be nurturing or poisonous. The medication can function as a relational bridge, a 'transitional object' (Winnicott 1953), linking patient to care, with emphasis on its 'soothing, anxiolytic and substitutive functions during times of separation' (Tutter 2006). Equally, if the medication is viewed with suspicion by a patient who has basic mistrust of attachment figures, it may activate paranoia and can be experienced as alien, toxic, intrusive or frightening, resulting in side-effects or non-adherence.

A framework for relational prescribing

A relational approach to prescribing is of fundamental importance when working with patients with complex emotional needs and personality difficulties, but it is not focused on any particular diagnostic category. A relational approach can be applied to all

prescribing practices, both in psychiatry and in medicine in general, but it can be especially helpful when there is evidence of treatment resistance, complex comorbidities or ambivalence towards change (Mintz 2022).

We suggest a framework that promotes curiosity and moves beyond a mind–body split to help clinicians consider relational factors when prescribing (Box 7). Prescribing is such an integral activity in our everyday jobs as clinicians that it is difficult at times to identify when we need help to remain mindful of what drives our prescribing practice. It is important to try to recognise when we do things outside of our usual practice. Sometimes we are alerted to this when patients deteriorate significantly or when their risk increases.

Case vignette 3

One of your colleagues is referring Sam, a man in his 30s, who presents with behaviours associated with obsessive–compulsive disorder (OCD). He experiences intrusive ego dystonic urges to poke his face and he engages in many numerical rituals to counteract his urges. His symptoms are very distressing and occupy most of his day. He lives alone and is socially isolated. Your colleague has treated him over 7 years with two selective serotonin reuptake inhibitors and clomipramine and has augmented treatment with aripiprazole. Sam received two courses of cognitive–behavioural therapy and, although he diligently attended and did his homework, no change was noted in his symptoms. Your colleague feels they have 'reached the end of the road' in what they can offer, and they are requesting a fresh opinion. At the time of the referral, Sam is on a medication-free period.

Sam attends and it is clear that he is very distressed but places a lot of hope in you and says he 'will do whatever it takes'. You thoroughly review his notes. He has a traumatic early life. He spent his first years in a care home, until he was finally adopted at the age of five; however, he suffered physical abuse within the adoptive family and feels 'failed by the system'. On review of all the available information and from your clinical impression you think that the OCD serves as an emotion regulation strategy and Sam has emotionally unstable personality disorder with comorbid depressive disorder. Sam feels relieved when you reformulate his symptoms and on hearing you are trying to 'get to the bottom of the problem'. You decide to prescribe venlafaxine and a few weeks later you add risperidone to aggressively treat his very distressing experiences. You continue to see him regularly to titrate the risperidone and to monitor his mental state.

Sam attends his monthly appointments and is very grateful for your input, but he appears to be deteriorating. On one of the reviews, you become aware that he had attended an accident and emergency (A&E) department between appointments. He was feeling suicidal but was not sure why. Following his A&E assessment, the duty worker suggested that Sam kept his upcoming appointment with you to 'have his medication reviewed'. You decide to further increase the risperidone as some patients see benefit on higher doses. When you return to work following a short break, you find that Sam has taken an overdose of risperidone. He is very apologetic, letting you know that he is not sure what got to him. You feel alarmed and decide that you need to step back and think what may be going on.

The following questions are a framework that you and the supervision group can use to guide reflection. We describe possible formulations that may emerge from discussion below.

BOX 7 Questions to ask yourself or your supervision group

Patient factors

What is my patient's story?

What is my patient trying to communicate using words or, as important, their actions in the here and now? (The function of what they are doing may be more important at times than the verbal content)

What may my patient lose or be exposed to if they were to 'lose their symptom(s)' and 'get better'?

Clinician factors

How do I feel in response to my patient and how does that influence the action I am considering taking? (e.g. do I feel helpless, frustrated, incompetent, guilty in the face of the patient's symptoms? It is important to realise you might not be able to be too specific about your feelings – an increased anxiety might in itself be an initial clue to some relational dynamic occurring)

Am I prescribing to promote or avoid emotional contact in my relationship with my patient?

Clinician–patient relationship

What might prescribing a medication – or not prescribing – come to represent in my relationship with my patient?

Patient factor

What is my patient's story?

Remember that this is your perspective on the patient's story, which may be a greater 'sum of the parts' based not only on the verbal – what your patient has told you – but also on the non-verbal – the patient's behaviour and your countertransference (what additional information may you be gleaning from understanding your countertransference?).

Sam has a history of having to depend on neglectful and abusive authority figures who have let him down. He has had to navigate life using his own resources. His OCD symptoms seem to take over at the expense of relationships with other people, reaffirming a punishing and abusive relationship with his own body and mind.

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What is my patient trying to communicate, using words or actions, in the here and now?

Sam wants to be cared for and understood. Sam seeks to trust and depend on a benign authority/powerful expert who might be able to provide a concrete solution to his predicament and rescue him from his distress. However, despite his treatment adherence, there is a regressive aspect to his presentation (malignant regression – see Box 8). Within the context of the increased care offered, Sam ends up putting himself at risk in ways that he cannot understand. He might feel that emotions are difficult to understand and symbolise. Relationships with others can be too risky and unpredictable. Sam might need a concrete response to know he is cared for. Prescribing validates his distress and provides him with a 'safe and concrete' relationship with a trusted professional.

What may my patient lose or be exposed to if they were to 'lose their symptom(s)' and 'get better'?

If Sam's symptoms were to 'get better', he might be brought in touch with his losses and associated painful feelings; he might be confronted by how lonely he feels in his life. He may also be anxious that he would no longer be under the care of a professional, which he may fear would mean that he would not have anyone looking after him and trying to help him.

Clinician factor

How do I feel in response to my patient and how does that influence the action I am considering taking?

Sam is grateful and makes me want to help him. I want to make a difference and not fail him as the rest of the system has done. I have considered taking a more aggressive approach to tackle a treatment-resistant illness, but I recognise that it has backfired and now I feel at a loss, hopeless, guilty that I might have brought this on, and embarrassed in front of my colleagues. If I am honest, I feel a bit frustrated with Sam for not responding to all my efforts and on top of it all to have developed suicidal thoughts.

BOX 8 Malignant regression

Malignant regression is a term introduced by Balint to describe a phenomenon that takes place in the context of a therapeutic relationship whereby the patient deteriorates under the care of the clinician. This is seen often in patients with developmental trauma and can represent the unconscious re-enactment of earlier traumatic relationships.

Am I prescribing to promote or avoid emotional contact in my relationship with my patient?

I feel I am prescribing to promote emotional contact, because I really empathise with Sam's distress and want to alleviate it. However, I am avoiding feeling his sense of despair and some of the irreparable damage that was done in the past. I want to avoid connecting with the pain of his trauma by offering him a solution and an escape from his painful reality.

Clinician–patient relationship

What might prescribing a medication or not come to represent in my relationship with my patient?

I think my prescribing is a response to Sam's early history of deprivation and my need to give him something (in response to his request to take something). On a symbolic level it could represent giving him hope and a cure. The medication is an extension of my relationship with Sam. However, the well-intentioned tablets can turn poisonous if I am not there (Sam might unconsciously project his hateful feelings on to me and experience my absence as an attack). Giving him the tablets could symbolise the experience of his adoption that carried the promise of a new life but turned into an abusive experience.

Using the revised formulation

When you next see Sam, following his overdose, influenced by the above formulation, you might have a different conversation, based on your greater understanding through reviewing patient, clinician and clinician–patient factors:

> Sam: I'm very sorry Doctor. Something took over me. My OCD is going mad at the moment, sometimes it feels this is all I have in my life. I take all your tablets religiously, but something is not working. I am not suicidal; I really want to get better.
>
> Doctor: I can hear how desperate and distressed you feel. I have prescribed venlafaxine and risperidone because there is evidence that they can help your symptoms. However, something is not working. I think we need to take a step back and look at what happened.
>
> Sam: Could it be that there is another tablet that is better for me? I've looked up lamotrigine, I haven't tried this one before.
>
> Doctor: Let's try not to rush into prescribing something else too soon. I actually don't want to make too many changes to your medication at the moment but given your overdose and the fact that you couldn't understand what happened, it might be safer to dispense fewer tablets at a time. I'm mindful that you've just said that your OCD is all you have in your life right now. I wonder if this may also be your way of telling me that you feel very lonely. It may be a good idea if we can talk more about yourself and your life outside your symptoms.

MCQ answers
1 a 2 b 3 e 4 a 5 b

Sam: [sighs] … I feel I have nothing left outside my symptoms. It's pathetic, I know. I wouldn't know where to start [starts crying].

Doctor: I can see how painful this is for you … maybe this is something important to hold in mind when we're thinking about what treatment choices we may want to make in the future. What do you think Sam?

Conclusions

In this article we have described the importance of considering non-pharmacological factors in prescribing outcomes and we provide a relational framework to help clinicians to reflect on complex prescribing dilemmas. We are advocating a psychodynamic understanding of prescribing practice that goes beyond following algorithms for psychiatric disorders. Symptom exacerbation, for example, could be an important communication about the prescribing relationship rather than relapse of a depressive illness. We suggest that being curious and reflective about interpersonal and psychological factors allows for a more thoughtful approach to prescribing, which can improve outcomes and reduce unwanted harm, especially for patients with so-called treatment-resistant presentations and/or complex needs. It will also help prescribers find meaning in complex consultations and it will reduce burnout. We suggest the use of supervision, reflective practice groups and knowledge of key literature to enhance and enrich the use of the framework developed here and influence prescribing practices.

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Author contributions

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MCQs

Select the single best option for each question stem

1 The clinician's emotional response might affect their prescribing practices. The psychodynamic concept often used to understand this is:
a countertransference
b unconscious conflict
c containment
d acting out
e malignant regression.

2 As regards relational prescribing/relational medicine:
a it is only relevant to patients with difficulties in keeping with a diagnosis of personality disorder or treatment-resistant presentations
b it can be applied in every area of medicine where there is a patient–clinician interaction
c it does not consider the patient's readiness to change and their ambivalence about losing their symptoms
d it dictates that when symptoms cause distress, they can never have an adaptive function
e it does not have any evidence to support it.

3 In the context of the patient–clinician relationship, medication might:
a function as a transitional object
b be seen as a communication that the clinician has listened
c be seen as a sign of care and nurture
d be seen as harmful and poisonous
e all of the above.

4 As regards the relationship between attachment and prescribing:
a patients tend to relate to professionals in similar ways to how they relate to their attachment figures
b there is no evidence of the influence of attachment style on pharmacological outcomes
c a patient with an anxious preoccupied attachment will never seek reassurance on potential side-effects of their medication
d patients who have history of trauma and abuse from attachment figures will often trust their prescriber blindly
e patients with insecure attachment styles are more likely to benefit from medications.

5 What is the potential risk when prescribing for a patient who does not response to multiple treatments?
a the clinician might be at risk of aggressive behaviour from the patient/their carer
b the clinician might increasingly prescribe more aggressive treatment regimens and risk harming the patient
c the clinician risks getting a complaint from the patient
d the clinician risks disapproval from colleagues
e there is no risk as long as the clinician follows the relevant treatment-resistance algorithm.