

ADVERSE EFFECTS AND IATROGENESIS IN PSYCHOTHERAPY

NOOMEN GHRAIBA / PSYCHIATRY - JORDAN / USA

n_gharaibeh@yahoo.com

Abstract:

This article reviews the literature and discusses evidence for and against adverse effects as well as iatrogenesis due to psychotherapy. The article attempts to distinguish between "adverse effects" and "iatrogenic disorders." The article concludes that there is credible evidence that psychotherapy may cause adverse effects as well as iatrogenic disorders. The skill and competence of the therapist delivering the psychotherapy is a very important variable in the risk of developing adverse effects or iatrogenic disorders.

▪ Introduction:

Even with the best of intentions, undesired negative effects may result from psychotherapy.^{1,2} The terms "side effects," "adverse effects," "iatrogenesis," and "iatrogenic disorders" are used interchangeably in psychiatric literature.³ I propose differentiating between "adverse effects" and "side effects" on the one hand and "iatrogenesis"/"iatrogenic disorders" on the other in order to avoid vagueness and confusion and to lend more precision to the terms used. In pharmacotherapy, for example, sedation may be considered an adverse effect (also called side effect) since it will cease with cessation of treatment. However, tardive dyskinesia or lithium induced hypothyroidism may not subside with cessation of treatment and therefore better referred to as "iatrogenic disorders." The differentiation between adverse effects/side effects and "iatrogenic disorders/iatrogenesis" is to emphasize the chronicity—if not permanence of the iatrogenic disorders.

"Iatrogenic" is defined in Webster's dictionary as: "Resulting from the activity of a physician. Originally applied to a disorder or disorders inadvertently induced in the patient by the manner of the physician's examination, discussion, or treatment, it now applies to any condition occurring in a patient as result of medical treatment, such as a drug reaction."

"Iatrogenesis" had been used in the psychiatric literature to refer not only to disorder(s) but also to refer to side effects/adverse effects as well. I propose limiting the use of "iatrogenesis" and "iatrogenic" to the enduring effects of the psychotherapy after the treatment ceases. Adverse effects as well as "iatrogenic disorders" have been well studied in pharmacotherapy. In psychotherapy and psychosocial interventions the data is spotty. The goal of this study was to review the literature for evidence for, as well as against, adverse effects and iatrogenic disorders in psychotherapy.

While engaged in psychotherapy some patients experience worsening of symptoms and/or deterioration of functioning. Bergin is credited for first raising the point of negative outcome in psychotherapy which he called the "deterioration effect."

I. Dependence:

The term "Iatrogenic Dependency Disorder (IDD)" occurs once in MEDLINE as used by Straton⁷ to describe the excesses of some Australian psychotherapists, such as a psychiatrist billing for 900 visits for one patient over one-year period, and

another psychiatrist claiming 747 sessions for one patient over one year. Straton does not seem to imply unethical conduct—despite the appearance of it—but implies that some psychotherapists induce a dependency in their patients that is pathological and counter-therapeutic. Although it is widely accepted in psychotherapeutic circles that the "sick role" implies an element of dependency, it is not agreed upon how far this dependency should go or how necessary or helpful it is.

The familiar phenomena of patient's deterioration when the therapist is away on vacation, sick or maternity leave speaks to possible excesses in dependency. One may argue that competent therapists should build up their patients' internal resources to carry them through the therapist's unavoidable absences or change of therapists, which is bound to take place one time or another. It is only human to desire to be needed, liked, wanted, admired, and respected, and it may be reaffirming for some therapists to feel that patients cannot function without their help.

The 1999 U.S. Surgeon General's Mental Health report emphasizes the need for patients and their families to be given a more prominent role in the mental health system. Encouraging active participation as opposed to passive dependence is thought to improve patients' satisfaction. The rationale derives from a clinical prediction that a patient centered approach (also known as consumer-centric approach in managed care circles) will lead to improved outcomes through "self-reliance, personal resourcefulness, information & education, self advocacy, self determination, and self-monitoring of symptoms."

Dependency is a human attribute that exists as a continuum: in the extreme of cases, dependence on the therapy/therapist or on a program/institution becomes as powerful as dependence on a drug of abuse. Since "seeking help" implies a measure of dependence, the logical approach is seeking "moderation" in the dependence-independence dimension since the two will co-exist in varying degrees. By the same measure, there are not that many patients (or humans in general) who are "totally independent."

II. False memories:

Despite the bitter debate regarding false memories, there seems to be increasing evidence that false memories can be induced in research as well as clinical settings. Due to ethical and practical considerations, empirical data to causally link the administration of psychotherapy to the creation of false memories is likely to remain deficient.

III. Worsening of symptoms and regression:

In a study of cognitive therapy and imaginal exposure in chronic posttraumatic stress disorder (PTSD), worsening was reported in 12 out of 62 patients—9 out of 29 in the exposure group and 3 out of 33 in the cognitive group. The results were challenged on methodological grounds. A later comparative study of exposure therapy, eye movement desensitization and reprocessing (EMDR), and relaxation training in PTSD with 15 patients completing each treatment indicated no worsening in exposure or EMDR and one worsening in the relaxation group. The authors of this study indicated that further research is required regarding the issue of worsening and suggested that the skill of therapists may be an important factor.

IV. Indoctrination:

One form of indoctrination in psychotherapy is a patient's self deception. The patient trying to resolve any real or perceived disagreement with the therapist accepts what the therapist overtly or covertly offers when it is not really the case. A second form is normalizing the dysfunctional in which the "extreme" in support and validation give the patient the message that a particular symptom or behavior is "normal." A third form is the opposite, i.e. pathologizing the "normal" mirroring the therapist's stance by viewing a certain phenomenon as pathological when in reality it is not. A theoretical study suggested that labels, language, and the tacit assumptions of therapists' "professional belief system" introduces the patient to this belief system and influences the patient's self-perception. The same study suggests that the patient gets "socialized" into a "pathology-oriented belief system."

V. Superficial Insight:

A quick internet search for the phrase "superficial insight" reveals that it is used mostly in a pejorative sense to mean poor understanding, superficial knowledge, lacking depth, etc. However, in the context of psychotherapy, I am referring to the insight acquired in psychotherapy but not resulting in any positive behavioral change, amelioration of symptoms/distress reduction, and/or improved level of functioning. Some therapists follow in the footsteps of motivational speakers and authors of self-help books who provide simplistic solutions for the masses (not for a particular individual with particular circumstances). Driven by a strong urge for simple answers, patients may be at risk of arriving at simple conclusions that seem to get to the "bottom" of the problem when in fact it does little to change behavior, symptoms, or functioning.

Acquiring "empty language" is a form of superficial insight. The patient incorporates the psychotherapy jargon as part of their everyday vocabulary without sufficient understanding of the concepts at hand. The patient talks with excessive abstractions, generalizations, and phrases that seem "deep" but mean very little. In their interactions with their families, patients may assume a "therapist's role" and use therapy-acquired language (jargon) for oration, to frustrate family, "outsmart" them, and to win arguments. Some patients use the technique they learned in their therapy to interact with family as if they were not part of the family, rather an observing amateur therapist.

VI. Acquiring new symptoms and/or dysfunctional behaviors:

There are more questions than answers in this area. For example, are patients at risk of acquiring new symptoms in psychotherapy? Does group psychotherapy contribute to some

patients acquiring dysfunctional habits they did not have before the treatment commenced? Other risks were mentioned earlier such as increased dependency, false memories, and worsening of the original symptoms of the patient.

Space does not allow for a detailed review of the controversy over the role of iatrogenesis in Dissociative Identity Disorder (DID) which was comprehensively reviewed elsewhere. These reviews (in two parts) present evidence to therapists-induced creation or worsening of symptoms in DID as well as a rebuttal/denial of iatrogenesis.

In-group psychotherapy patients are exposed to different psychopathology and dysfunctional behaviors other than their own, risking learning through modeling and copying from other patients. Adverse outcomes in-group psychotherapy are well documented.

VII. Iatrogenic Malingering:

Iatrogenic Malingering" is cited once in MEDLINE as used by Pierre, Wirshing and Wirshing. There is usually subtle and well-intentioned coaching of the patient by the psychotherapist for more access to services, longer treatment, or more frequent treatments. With managed care's financial restrictions, this phenomenon may be much more common than suggested by a single citation in the literature.

Discussion and Conclusion:

In the mental health field, many theories and practices are expected to result in a lot of variability in the administration of psychotherapy. Negative outcomes tend to be a small fraction of published articles in the psychiatric literature when compared to positive outcomes. The arguments above highlight the inevitable disagreements in answering sensitive questions about potential harm done to patients by well-intentioned therapy. Since "completely eliminating any negative treatment effects is unrealistic and perhaps only accomplished by ceasing all treatment," the goal must be reducing the risk, not completely eliminating it.

Just as much as side effects of medications are "dose-dependent," adverse effects in psychotherapy are "competence-dependent." It is fair to assume that the less competent the therapist is, the higher the chances of possible adverse effects or iatrogenesis. Even with the best of intentions, poorly planned and/or poorly executed therapy will have negative impact on the wellbeing of some patients.

Although this review raises more questions than answers, it intends to shed some light on the dark and often neglected area of negative outcomes. It raises the following questions: How common are negative effects and iatrogenic disorders in psychotherapy? What are the factors involved in increasing the risk of adverse events and iatrogenesis? And, how can such risk be reduced?

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ميثاق القاهرة 2005

العوامل النفسية للعنف والإرهاب

الجمعية العالمية للطب النفسي هي أكبر تجمع لأطباء النفس في العالم وتكون من 130 جمعية تمثل 114 دولة، إن خبرة وتدريب الطبيب النفسي تشمل الصحة النفسية والسلوك الإجتماعي للأفراد، وبما إن تراكم المعرفة العلمية في الصحة النفسية تشير إلى أن الكوارث التي يصعبها الإنسان من حرب، إرهاب، القتل الجماعي وما شابه تؤدي إلى إلهاء الحياة، وتسبب مضاعفات نفسية واجتماعية للأحياء الباقين في أنحاء العالم.

يعتبر العنف مشكلة في الصحة العامة والصحة النفسية، والعنف له جذوره الاقتصادية والاجتماعية والسياسية، وعادة ما تقترب هذه الكوارث بأسر الدين والمبادئ الوطنية. وكل ذلك الجاهات تطفية لحوياة الإنسان.

أن العنف يؤدي إلى العنف، والنكاثف والتعاون يعزز السلوك السوي،. نحن في أشد الحاجة لتعديل النظر المعرفية الحاطة الاتجاهات التخريبية.

إن الفقر والتهم والاحتلال وعدم حرية التعبير وغياب الديمقراطية يجب التعامل معها على المستوى العالمي.

ويزدهر العنف مع عدم وجود الحاجات الأساسية من طعام، مسكن، صحة وغياب العدل، وحث كل الأديان على الرحمة وبذ العنف والإرهاب والسامح وهي ضروريات الصحة النفسية السوية.

تهيب الجمعية العالمية للطب النفسي والتي تمثل ما يفوق مائة وخمسة وسبعون ألف طبيباً نفسياً أنتظراً لزيادة الإرهاب والعنف في العالم نتوجه بالآتي:

- ندعوز عماء العالم بنبذ البدء أو تصعيد الكوارث البشرية، ومن ثم تخفيف معاناة الشعوب والتي لها التأثير السيئ على الصحة النفسية في العالم أجمع.
- نذكر صانعي السياسة أن المعرفة العلمية في الطب النفسي تستطيع تقديم الطرق النفسية والاجتماعية لمواجهة الصراعات وحلها.
- تشجع عماء العالم لإيجاد الحلول لجودة حياة مواطني العالم.
- استكشاف ما يمكن عمله لكي يعيش الإنسان في بيئة خالية من الإرهاب والعنف في المستقبل.