

Mirela Vlastelica

Private Psychiatric Office, Split, Croatia; Department of Psychological Medicine, School of Medicine,
University of Split, Croatia

How to deal with psychopharmacotherapeutic inefficiency

Jak radzić sobie z nieskutecznością psychofarmakoterapii

Abstract

There is more need in the pharmacotherapeutical treatment, particularly in psychopharmacotherapy, to take into account the psychological factors that influence the effectiveness or ineffectiveness of treatment. It's important to take into account the holistic approach to the patient and a "brain-mind" concept is also inevitable in this approach.

Inefficiency of pharmacotherapy, treatment-resistance, non-adherence, placebo etc. are only some of the phenomena that require a psychodynamic approach and the kind of creativity in prescribing drugs.

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Introduction

For a long time we have faced with problems of inefficiency of drugs in many psychiatric patients. We are faced with many problems of treatment-resistance, non-adherence, placebo phenomena, intense side effects, etc. These conditions frustrate us as psychiatrists as well as patients themselves. In the understanding of these problems can help us psychodynamic psychopharmacotherapy that represents a compromising approach between biological psychiatry (and psychopharmacotherapy) and psychodynamic psychotherapy. This approach includes many of the psychoanalytic and psychodynamic concepts, techniques, theories and therapeutical skills.

Operating from either a dogmatic psychotherapeutic paradigm or a psychopharmacological paradigm means to deny patient in his holistic integrity. Transference issues and patient's personality structure really have a greater impact on the selection, dosage, tolerability, and treatment outcome than is generally admitted.

How to deal with treatment resistance

Neuroscientific researches prove that "biological" and "psychological" constructs are impossible to disentangle, and according to that it is useful to accept

concept called "brain-mind", rejecting anachronistic dichotomy such as "mental" vs. "physical", "mind" vs. "body", "psyche" vs. "soma", etc. Accepting the application of "brain-mind" concept [1] offers explanation for many dilemmas, particularly for treatment resistance or non-adherence. Treatment resistance still remains as a serious psychiatric problem. Dynamic factors in psychopharmacology in that way play an important role in pharmacological treatment responsiveness. Psychodynamic psychopharmacotherapy offers rational prescribing identifying irrational interferences with effective use of medications, and in that way trying to avoid the problems of the pharmacological treatment resistance.

Psychodynamic psychopharmacology addresses the central role of meaning and interpersonal factors in pharmacological treatment [2]. This approach includes postulates of psychoanalysis (the unconscious, conflict, resistance, transference, defense) as powerful factors in successful pharmacotherapeutical treatment and are concordant with it. However, in treatment resistant patients, it is likely that psychodynamic factors (usually unconscious) are not in the line with therapeutic aims. But we must also admit that with the aim of treatment optimization, certain phenotypic genetic biomarkers undoubtedly play an important role in the recognition of treatment-responsive and unresponsive patients, and they reduce the risk of drug toxicity by enabling individual dosage adjustment. Therapeutic drug monitoring and pharmacogenetic testing both may improve acute and

Address for correspondence:

prof. dr. sc. Mirela Vlastelica
Vukasovićeva 10, 21000 Split, Croatia,
Tel. 00385 91 410 0091,
e-mail: mirela.vlastelica@yahoo.com

long-term treatment, prediction of therapeutic response, possible correlations with treatment outcome, and monitoring of treatment compliance and can represent a prominent step towards creative psychopharmacotherapy. However, despite ample evidence to the efficacy of these individualized procedures, they are still met with insurmountable financial and educational obstacles [3]. Psychodynamic psychopharmacotherapy helps prescribers know how to prescribe pharmacy to improve outcomes, representing in a way an integration of biological psychiatry and psychodynamic insights and techniques. That fact can be simply illustrated by placebo phenomena, which produces real, clinically significant, and objectively measurable improvement. Producing measurable changes in brain activity placebo overlaps medication-induced improvements [4].

From a psychodynamic point of view, pharmacological-treatment resistance has different underlying dynamics and requires different kinds of interventions. Patients may be resistant to medication or resistant from medication. The first ones, resistant to medications, have conscious or unconscious factors that interfere with the desired effect of medications. It takes form of non-adherence but also in nocebo response. In contrast, resistant from medications are eager to receive the medication (or some benefit that the patient attributes to the medication) and although it may seem to relieve symptoms, there is no improvement in the patient's quality of life. Resistance to medications and resistance from medications are not mutually exclusive, and many patients present both dynamics.

The resistance phenomena are first described by Freud in 1905. when he discovered that many patients were unconsciously reluctant to relinquish their symptoms or were driven, for transference reasons, to resist the doctor. The same dynamics may apply in pharmacotherapy and may manifest as treatment resistance. When symptoms constitute an important defense mechanism, patients are likely to resist medication effects until they have developed more mature defenses or more effective ways of coping. Defense mechanisms play important role in dynamics of resistance and vice versa [5].

Treatment-resistant patients do not function better with pharmacotherapy; on the contrary, some of them get worse. There are countless ways these medications may serve countertherapeutic and/or defensive aims.

Mintz and Belpap [2] explored the phenomenon of treatment resistance in relation to medications. Actually they proposed and defined a discipline of "psychodynamic psychopharmacology," described its philosophical underpinnings and offered technical recommendations for the psychodynamic treatment of pharmacologic treatment resistance. They suggest that many patients are

"treatment-resistant" because patient's psychodynamics is not incorporated into an understanding of repeated treatment failures. They also propose that psychodynamic psychopharmacology advances the overall clinical effectiveness of medications in treatment-resistant patients by integrating a psychodynamic appreciation of the patient with a psychopharmacologic understanding. The proposition of a new discipline, psychodynamic psychopharmacology, by D. Mintz and B. Belpap, offers not only a new discipline but also practical recommendations for the psychodynamic treatment of pharmacologic treatment resistance [6].

There are six principles for psychodynamic pharmacological practice with treatment-resistant patients [7]:

1. A psychodynamic psychopharmacotherapist completely refuses mind-body dualism, of course. Feelings, ideas, experiences, relationships... all that change the structure and function of the brain, just as the state of the brain influences experience. Mind-body integration also means that psychotherapy and psychopharmacology will need to be well-integrated so that psychopharmacological interventions facilitate the psychotherapy and so that the therapy helps the patient become conscious of psychological sources of pharmacological-treatment resistance.
2. The central tenet of psychodynamic psychopharmacology is like somebody said: "It is much more important to know what sort of patient has a disease, than to know what sort of disease a patient has." This practically means that the pharmacotherapist should get patient's developmental and social history to make reasonable hypotheses about the psychological origins of the patient's treatment resistance.
3. It is important to identify potential sources of ambivalence about symptoms, such as secondary gains, and communicative or defensive value of symptoms. It may be helpful at the point of intake to ask the patient what he would stand to lose if treatment was successful.
4. Negative transferences must be identified and worked through. Once potential sources of resistance to the medication or the doctor are understood, these must be addressed. If they are clear at the outset, they must be addressed preemptively. In this way, an alliance is made with the patient before massive resistance is sparked. Empathic interpretation of nocebo responses can resolve adverse effects [7].
5. Countertherapeutic uses of medications should also be interpreted. A prescriber sometimes might be tolerable to the patient's irrational use of medications, understanding that the patient is working through an issue that interferes with a healthier use of those

medications. In that way, psychopharmacotherapist can expect a condition of continued pharmacological treatment instead of countertherapeutic uses.

6. A medication regimen often reflects countertransferential experience of the psychopharmacotherapist and such a regimen is unlikely to be effective. Sometimes is perhaps aimed at treating the doctor's anxiety rather than the patient's; the patient is not the only source of treatment resistance. A psychodynamic psychopharmacotherapist must recognize his countertransferential problems in order to manage irrational prescribing.

Prescribing medication, psychopharmacotherapist always has to obtain the so called „psychotherapeutic frame“ [8]. That frame is containing psychotherapy, within certain place and times and under certain condition, i.e. psychotherapeutic setting.

Psychoanalytically speaking, on the part of the patient, frame comes to represent the most primitive part of the personality — it is the fusion of the ego-body-world on whose immobility depends the existence. Especially psychotic patients bring, in the most obvious way, their own frame into their therapy, and the therapist is the one who must enable to develop it into a stabilizing foundation on which the organization of the personality can take place. The psychotherapeutic frame is a permanent presence for the patient, and is comparable with the Winnicott's concept of “holding” [9].

Placebo and therapeutic alliance

Examples of the placebo effects can be found in every field of medicine. Mechanism of action of this phenomenon is yet unknown although researches focused on the expectation model, the model of conditioned reflexes and the opioid model which are probably complementary. Lots of researches in this field show that thoughts and beliefs can have important influence on the human neurobiology and create therapeutic process in that way. It is important to continuously develop consciousness, especially through educational processes during the medical education, about the importance of placebo and nocebo phenomenon and then in clinical practise to keep in mind not to send messages that lower the patient's hope. Psychiatry is the field of medicine where placebo and nocebo effects are mostly expressed and in concordance with that researched the most, especially in the treatment of depression, although placebo effect is impressive even in some studies on patients with schizophrenia [10].

The patient's desire to change and his positive transference can mobilize profound self-healing capacities. Re-

adiness to change is powerful determinant of treatment effectiveness, sometimes more potent than the type of the therapy [11].

There is a large placebo-controlled, multicenter trial of treatment of depression that showed that patient were most likely to respond when they received the active drug but had a strong therapeutic alliance, which in its essence contents positive transference phenomena. Patients who received placebo and had a strong therapeutic alliance had a significantly better therapeutic response than patient who received an antidepressant but had a poor therapeutic alliance [12].

While positive transference often lead to positive responses, negative transference are likely to lead to negative responses, to nocebo responses [13]. Many of them who experience intolerable adverse effects to medication are nocebo responders, and many of them become treatment-resistant.

Psychodynamic approach and attachment

Psychodynamic psychopharmacotherapy and “brain-mind” concept can be observed in the frame of transdisciplinary holistic integrative psychiatry, that is approach “...built on the premise that human beings in health and disease are complex systems of dynamically interacting biological, psychological, social, energetic, informational and spiritual processes” [14].

And psychodynamic psychopharmacotherapy in that mean accepts the application of “brain-mind” concept resolving many dilemmas, putting at the stake questions of compliances, nonadherences, placebo, nocebo, therapeutic alliance, treatment resistance, etc. [15].

Psychodynamic theory is a framework that could be helpful in clarifying our understanding of non-adherence. In particular, looking at the contributions of attachment theory and research has allowed us to deepen our understanding of non-adherence. Strengthening the therapeutic alliance and fostering collaborative physician-patient relationships may result in improved adherence [16]. Cohen and his colleagues in 2001. have written about the connection between early childhood trauma and non-adherence or resistance in adult patients with posttraumatic stress disorder and comorbid depression. They postulated that traumatized patients' sense of a foreshortened future may be related to failure to engage in or accept medical treatment, which suggests that early childhood trauma is a psychological risk factor for adult non-adherence [17]. Psychotherapeutic interventions based on attachment theory could help patients who are nonadherent to treatment by stressing the importance of collaborative relationships, relinquishing excessive self-reliance and control, and promoting trust. Each modality

of treatment, either psychotherapy or pharmacotherapy, or their synergistic combination, may be effective in the light of "brain-mind" concept. Applying that concept in the frame of psychodynamic psychopharmacotherapy resolves many previous dilemmas, and particularly questions of compliances or non-adherences, placebo or nocebo, therapeutic alliance or treatment resistance, etc. Empathy and attachment are those to address the problems of non-adherence. There is a lack of information concerned with the psychological aspect of prescribing medications. This is striking since many patients require both treatments. As prescribers, our lack of empathy often stems from an unconscious need to feel isolated from our patients, to defend ourselves against overwhelming distress and maintain emotional distance. A collaborative stance promotes adherence, while paternalistic or categorical medication advice could be perceived as coercive and could result in non-adherence. A recent focus on the interface between attachment theory and psychoanalytical theory has deepened our understanding of the psychodynamics of non-adherence.

Attachment theory is based on the premise that early life experiences with caregivers (mother, parents, or their substitute) are internalized and determine how individuals relate to others in adulthood [18]. Attachment concepts were originally conceived to understand the evolutionary, adaptive, and biological aspects of parent-infant care giving. Most recently, clinical research has validated the usefulness of attachment concepts in understanding non-adherence [19].

The disruption in attachment bonds can lead to problematic behavior during childhood and possibly across the life span. Research has demonstrated that the caregiver's sensitivity to the infant's needs is essential to ensure secure attachments. Adults with secure attachment experienced consistently responsive caregiving parents, while adults with dismissing attachment had avoidant parents who were consistently emotionally unresponsive. Adults with secure attachment are comfortable depending on others and are readily comforted by them. Adults with dismissing style become compulsively self-reliant, describe themselves as independent and self-sufficient, and are uncomfortable being close to or trusting of others. Awareness of dismissing attachment behaviors in our nonadherent patients can help us reframe our psychotherapeutic work. Wallin describes the process of therapeutic interventions with dismissing individuals as "moving from isolation to intimacy." In the early stages of treatment, he encourages a keen awareness of subtle affective cues and nonverbal communication, to help patients be comfortable in letting others in and in being treatment collaborators [20].

A collaborative approach must be based on a mutual respect, trust, and openness that, along with an awareness of typical transference and countertransference issues, can increase the likelihood of a positive treatment outcome [21]. Psychodynamic psychopharmacology creates opportunities for a richer and more effective understanding of the entire therapeutic process, in which pharmacotherapy is applied in the treatment of mental disorders. It is a way of thinking about the pharmacotherapy of mental illness that incorporates both pharmacological and psychodynamic knowledge in a practical clinical approach and treatment-related decision making [22]. It is also very important to integrate psychodynamics and neuroscientific data because of similar patterns that exist in them. Many neuroscientific discoveries have just reaffirmed the psychodynamic postulates (just to mention concept of "attachment" and the role of the limbic brain). Medical psychoanalysts, who comprehend dynamic and brain mechanisms should find an increasing theoretical and practical convergence of their work. The dynamic psychiatrist actively participates in the resolution of a given symptom picture and fosters improvement of the patient's personality structure to maximize functioning [23].

In every illness, both mind and body can be affected to different extents. It is difficult to discern which manifestations of an illness are rooted in the body and which in the mind. Evidence shows that psychotherapy influences the biology of the brain, and that pharmacotherapy influences the psychological, social and developmental dimensions of the individual as well as their overall functioning and well-being. Every practicing physician, regardless of their medical discipline, uses in their everyday practice both biological and psychological approaches to help successfully treat the patient [24]. Each set of interventions influences cerebral electro-chemical processes and each takes place within an evolving therapeutic relationship which proceeds through different stages. One of the major challenges to current clinical psychiatry is the development of firm guidelines for combined therapy [25].

In contemporary psychiatry, a psychodynamic perspective must be preserved because without it, both diagnostic understanding and treatment planning will suffer [26].

Conclusion

This viewpoint considers the phenomena that inhibit or hinder psychopharmaceutical efficiency: treatment resistance, nocebo, non-adherence, transference and therapeutic alliance problems and many others.

It is underlined the importance of psychodynamic psychopharmacotherapy and holistic approach to the patient.

Streszczenie

W leczeniu farmakologicznym, a zwłaszcza psychofarmakologicznym, powinny być w większym stopniu uwzględniane czynniki psychologiczne, które wpływają na skuteczność lub brak skuteczności leczenia. Ważne jest wzięcie pod uwagę konieczności całościowego podejścia do pacjenta, a w ramach takiego podejścia koncepcja wzajemnej relacji „mózgu–umysłu” jest czynnikiem, który nie może być pominięty. Brak skuteczności farmakoterapii, oporność wobec leczenia farmakologicznego, trudności w przestrzeganiu zaleceń, efekt nocebo to jedynie kilka przykładów zjawisk, których zrozumienie i poradzenie sobie z nimi wymagają podejścia psychodynamicznego i pewnego rodzaju kreatywności w sposobie stosowania farmakoterapii.

Autorka proponuje zastosowanie zasad i metod psychodynamicznej psychofarmakoterapii w celu rozwiązywania problemów w trakcie prowadzenia terapii lekami psychotropowymi, a także uwzględnienie zjawisk opisywanych przez teorię przywiązania w kontekście poprawy współpracy w leczeniu, stosowania się do zaleceń oraz w celu tworzenia wzajemnej relacji terapeutycznej w ramach poprawy skuteczności farmakoterapii.

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słowa kluczowe: brak skuteczności farmakoterapii, podejście psychodynamiczne, całościowe podejście do pacjenta

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