Euro Psychiatry Summit-2015
July 20-22
Barcelona, Spain

Euro Global Summit and Medicare Expo on
Psychiatry
July 20-22, 2015 Barcelona, Spain

How to deal with psychopharmacotherapeutic inefficiency

Mirela Vlastelica
University of Split, Croatia

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-resistence, non-adherence, nocebo 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 denial patient in his holystic intergity. 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 anachronic dychotomy such as "mental" vs."physical", "mind"vs."body", "psyche" vs. "soma", etc. Accepting the application of "brain-mind" concept (Stein 2008) 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 psycho pharmacotherapy 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 (Mintz & Belnap 2006). 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 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 (Kores Plesničar & Plesničar 2014).

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 (Mayberg 2002). 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 seems 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 (Vlastelica et al.

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 Belnup (2006) 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 (Mintz & Belnap 2006). 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. Belnap, offers not only a new discipline but also practical recommendations for the psychodynamic treatment of pharmacologic treatment resistance (Murawiec 2008). There are six principles for psychodynamic pharmacological practice with treatment-resistant patients (Mintz 2006): 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

- 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. 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.
- 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 (Mintz 2002). 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.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 sychopharmacotherapist must recognize his countertransferential problems in order to manage irrational prescribing. Prescribing medication, psychopharmacotherapist always has to obtain the so called „psychotherapeutic frame“, 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”.

Conclusion

This viewpoint considers the phenomena that inhibit or hinder psychopharmaceutical efficiency: treatment resistence, nocebo, non-adherence, transferential and therapeutic alliance problems and many others.
It is underlined the importance of psychodynamic psychopharmacotherapy and holistic approach to the patient.