

# Adherence to Chronic Therapies in Psychiatry: From Treatment to Cure. The Relevance of Therapeutic Relationship

Sergio Mungo<sup>1\*</sup> and Michele Fornaro<sup>2</sup>

<sup>1</sup>Department of Neuroscience and Psychiatry, University of Genoa, Italy

<sup>2</sup>Department of Educational Sciences, University of Catania, Italy

## Introduction

It has been said that, a primary determinant of treatment success is adherence to therapy [1]. A lack in adherence to psychiatric therapies has been shown to result in an increase of relapses, re-hospitalizations, evolutions towards chronicity, various kinds of psychic and somatic complications, and an increase in health care costs. According to the World Health Organization, the degree of low adherence toward medication, in all illnesses in general, is so great and the consequences are of such concern, that worldwide people would benefit more from the efforts to improve adherence than from the development of new medical treatments [2]. In Psychiatry, this problem seems to be more relevant than in the rest of Medicine. Counseling about medication adherence for the three major diseases states: in Schizophrenia, Mood Disorders, and Personality Disorders, that is important to educate patients and their families about the consequences of not appropriately treating these conditions, which can result in psychotic attacks, increases in aggressiveness, suicides, potentially permanent losses of social skills and devastating alterations to their quality of life [3].

## Compliance and Adherence

Compliance once widely used and sometimes confused with adherence, refers to a patient's obedience to therapy under the authority of the physician, rather than to a collaborative approach. It is evident that we must abandon this term in Psychiatry, whereas the relationship between caregiver and patient is the main reason through which we can "take care". That is also the reason why we can speak of compliance in Psychiatry only when we refer to specific treatments in case of emergency, urgency, lack of consciousness or imminent danger for the patient himself or someone else.

Adherence is the degree to which the patient's behavior is in agreement with the health caregiver's recommendations. That is a collaborative approach between the patient and the psychiatrist in which the therapeutic relation makes a strong frame where the patient's values, lifestyle, and beliefs are still his own property, but he nevertheless can share with his "doctor" advice, opinions and prescriptions that concern the value of his own health.

Another term that relates to adherence is persistence, which is the patient's ability to continue taking the medication for the duration of treatment. Discussing the intended course of the therapy with the patient has been shown to help the patient follow constantly his or her medication regimen [4].

## Factors that Influence Adherence

The most consistently reported factors, which have had an impact on adherence in Psychiatry, are seriousness of illness, acute psychotic episodes, chronicity, relevance of side effects, low literacy, poor social support, elevated family grade of EE, and homelessness. Patient's beliefs about diagnosis and medication effects have also shown to affect the adherence rate. This is particularly true with psychotropic medications that are still objects of stigma and wide prejudices among

general population [2]. If an anti-diabetic drug can be seen only as a medication, a neuroleptic drug or even a simply hypnotic one, are generally felt like "real psychotropic drugs" that can modify the brain or the functioning of the mind. These sensations can cause a wide variety of reactions among patients, families, health officers, and so on, that go from scare, to curiosity, overtaking, and open refusal.

## The Role of a Third Significant Person

Psychiatrists, relatives, nurses, social helpers and even pharmacists can promote an increase in communications between health caregivers and patients. This at least will improve adherence and outcomes. Questions like, "What is my main problem? What do I need to do? Why is it important for me to do this?" All those who support patients should be able to instruct them to ask these three questions, state them to patients and answer them in case patients do not ask. When answering these questions, particularly with less-symptomatic patients, it is helpful to remind patients of the consequences of failing to take their medication, such as a devastating in their social or familiar relationship, in their abilities or individual suffering [5]. A full treatment adherence may include being interested in one's health and understanding the diagnosis, comprehending the impact or potential impact of the diagnosis, believing that what has been prescribed will help to know precisely how to take the medication and for how long. Other requisites may be determining how to fit the medication into one's daily routine, valuing the results of treatment more than the cost of therapy, believing that one can fulfill the treatment plan, feeling that the physician has true concern for the patient as a person, as opposed to the simple treating of the disease [6]. If a complete adherence to therapy is difficult to obtain in current medical practice, it is much more complicated in psychiatric practice.

## Adherence to Chronic Diseases in Psychiatry: Sisyphus between Pharmacological Treatments and Psychotherapies

### Poor adherence from illness

Sometimes the Psychiatric Disorder itself can lead the patient to misunderstand the meaning of his symptoms or miscalculate the secondary effects. For example: the presence of paranoid ideation may

\*Corresponding author: Sergio Mungo, Department of Neuroscience and Psychiatry, University of Genoa, Corso Italia 22, 16145 Genova – I, Italy, Tel: +39 3472701965; E-mail: [sergiomungo@libero.it](mailto:sergiomungo@libero.it), [mungo.sergio@gmail.com](mailto:mungo.sergio@gmail.com)

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lead the patient to the idea to be poisoned from the caregiver himself. The disappearance of symptoms is one of the main goals of medical treatment, but for a chronic schizophrenic patient that has been living for many years in a balanced relationship with “aliens” crowding his mind, their unexpected escape, secondary to a strong antipsychotic therapy, can scare him, until the extreme consequences of a grief. A depressed patient can lie to everyone about his adherence to an antidepressant therapy with the only purpose to refuse the recovery, or in some cases to accumulate drugs to attempt suicide [7]. Many patients try to manipulate therapists, nurses, relatives just because they strongly believe that they are not sick, or simply, they are not mentally disturbed, or do not want people to look at them as “crazy”. The adherence with psychiatric patients involves the ability of the psychiatrist and his helpers to create a close therapeutic alliance where the patient feels the strong sensation he is protected against everyone, even against his own rage.

The “frame” of the therapeutic relationship has to be so well-constructed as to resist to an extremely hard pressure, both from environmental factors and internal forces. Chronic Psychiatric Disorders treatment’s adherence requires a strong integration between psychological intervention and drugs administration [8].

### **When the refuse come from a lack of integration in the treatment**

The story of the integration between biological and psychological therapies in the treatment of Mental Disorders runs right through the history of Psychiatry and is well- represented with the myth of Sisyphus, where the interminable and frustrating psychiatric work is greatly due to the opposition brain/mind [9]. Within the specific context of Mood Disorders, antithetical positions are encountered which range from discouraging every association of psychotherapy with pharmacological treatment, judged to be useless or damaging, to the more recent re-assessments of psychological treatments, at least in cases of greater management complexity, including chronicity and/or poor adherence. In addition to the primary drug-phobia, which derives directly from primary psychiatric pathology or from a comorbidity disease, sometimes drug-phobia appears for the first time, or it increases, during a long-term treatment. Once all cognitive, rational and pharmacological tools have been unsuccessfully used, we should investigate more thoroughly within the therapeutic relationship. Consequently, what is possible to recognize, it is not limited to chronic therapy of psychiatric patients, but can be applied to many other medical treatments. The refusal of the drug sometimes arises from a mechanism of distrust and devaluation of the therapist, if not at times of ambivalence or aggression against him. Other times drug phobia may represent a focused mode and partial resistance to changes and the care that affect the drug, more like a metaphorical object, that as real and concrete danger. Sometimes the resistance to “healing” derives from secondary benefits relating to family relations, work privileges, love affairs, economic questions, being, however, the mechanisms that generate them completely unknown to the patient. In a case where the physician does not recognize a pseudo-resistance to drugs, he may increase his control on drug intakes and his interventions of reproach and coercion even indirectly on family members. On the other hand, if a pseudo-resistance to drugs appears to be a concrete resistance to care, the physician will be lead to a constant change in strategy thus devaluing his role [10]. Other times the pseudo-drug resistance ends to mask, the desire to continue the therapeutic relationship and this happens both when it may be easily recognized as an eroticized transfer, and when the patient has strong bonds of therapist addiction. In even more complex cases that are fortunately rare, during the treatment of chronic diseases,

a pseudo-drug resistance may appear, generated by deep feelings of guilt. The pseudo-drug resistance in a sort of moral masochism seems to grow when the therapist aims at reaching a fast healing or when the patient perceives as excessive his therapist’s narcissistic expectations.

### **One example: bipolar disorders. A pathology where psychotherapy might be superfluous**

Bipolar Disturbances, where the introduction of equilibrators seems to have swept away every need for psychotherapeutic treatment, and where we continue to see unexplainable relapses may represent a very particular situation [4]. Many Chronic Bipolar patients assume their stabilizer therapy, just for one week before its plasma dosing. We have to call it drug-resistance, non-responders, or simply do we have to look inside the medical-patient relationship? A poor and not psychotherapeutic oriented relation, where in some cases the physician as the only role of a drug-dispenser. The bio-technological supremacy of aseptic drugs such as the stabilizers is, in fact, stymied by a series of situations in which the emotional-affective instability, which remains after pharmacological treatment, is no longer biologically modifiable. The refusal of a new therapy cannot be read, at this point, only as an adherence’s reduction after years of treatment, but even as positive signal that the unconscious of the patient gives his therapist in order to try to understand and elaborate this instability only by psychological instruments [4]. Probably it will occur that in the chronic treatment of Bipolar Disorder, as in many other Psychiatric Diseases, a new drug therapy will have to be prescribed in the future. The “pause” the patient sometimes requires between two different biological interventions, can be managed better with psychological tools than with pharmaceutical dispositions, and, once again, the ineluctability of the renewal of psychiatric work recalls the fatigues of Sisyphus [11].

### **Another Obstacle to Adherence: the Stigma**

Environmental factors include still at the first place the “stigma” that mental illnesses have and the prejudices around psychotropic medications. Those factors influence the general attitude of the patient’s entourage to refuse, reduce, or to increase the prescribed therapies without any consultation from the caregiver or in the worst cases with his collusion [12]. Particularly symbolic meanings attributed to psychotropic drugs, heavily condition the feelings towards drugs. Moreover, the characteristics of many side effects and the appearance of frequent iatrogenic pathologies easily cause the worsening of the subjective suffering and the relational chances of the patient, thus leading to an accentuation of refusal, isolation, relegation and stigmatization of the patient from others. The management of all psychiatric treatments needs therefore a well-trained caregiver, who can work in a team, where nurses, social helpers and relatives play well-definite roles, whose purpose is the maintenance of the therapeutic relation inside the therapeutic frame. A group of people working together, is not a team, but fighting together against the “stigma”, may be the very first step to move towards the main objective, and finally, taking care of a person whose sufferings are not necessarily limited to somatic pain or glandular dysfunction, involves the essence itself of the personality and mind [13].

### **How to Overcome Adherence Challenges**

Whenever it is possible, a psychiatrist, as any other physician, must create a shame-free environment. He must promote open dialogue, using a plain language instead of a medical terminology, providing written communication when necessary. New interactive technologies may be useful in some cases, even simply picture or video instructions.

Involving family members, social helpers, home nurses as much as possible are goals very useful in long-term treatments. Simply things: like having the patient repeat the instructions, following up by telephone, to confirm the patient's understanding, play an incredible strong role in the maintenance of therapy [14]. In any case psychiatrists need to know also all the right strategies to overcome low health literacy. These entire rational and sequential steps are unfortunately non-sufficient in many cases [15].

### The therapeutic relationship. "Handle with Care"

Many other different factors can affect adherence to psychiatric cure. One first step is to prepare psychiatrists that can manage every treatment with a "psychotherapeutic attitude". They have to be able to understand that when they prescribe a therapy, they prescribe a little of themselves, and in all case the relationship with the patient is a metaphoric triangle, where the drug, the patient or even the therapist, may be excluded. A well-structured psychological training, may be useful, but unfortunately is not sufficient, if the physician has a not clear difference between compliance and adherence.

### The knowledge of pharmacodynamic and pharmacokinetic of psychotropic drugs is essential

Psychiatrists prescribe drugs that undergo the general rules of pharmacology. Rules that are too often forgotten: for example, a simplification of the dosing regimen can affect adherence in a significant manner. Sometimes repeated assumptions are not justified by pharmacokinetic properties of drugs, but by the need to treat relatives, environment or psychiatrist's anxiety.

In these cases the patient itself, some relatives, or even a nurse, may reduce the number of assumptions with an augmentation of single dose, without any medical approbation.

New antipsychotics, with their simplified regimen of administration, offer more advantages even in terms of adherence [16].

### The role of long-acting drugs – It is ever a good solution?

The use of long-acting therapy is in many cases a great solution, when all strategies were played but the patient still has a refuse of the biological therapy, or a poor or uncertain adherence. No doubts about the improvement on the course, reduction of relapses, prognosis and efficacy that these drugs have dramatically had on Mental Illness [17-19].

Here we have just to underline, that, if, at a certain point of a treatment, we can obtain a better adherence with oral drug, we might change the strategy of therapy. Long-acting drugs sometimes are felt as a coactive and distancing therapy [1,20,21]. Moreover, the clinical management of variations, side effects or interactions of depot drugs it is not always simple.

### Conclusion

Poor adherence to psychiatric medication is multifactorial, including mental illness itself with his capacities to create distortions in communications. A wrong adherence affects the patient's confidence and his understanding of the diagnosis and how the medication will help his prognosis. Many important questions to answer for the patient concern managing the most disturbing symptoms. What does the patient need to do? Why is it important for the patient to do this? After these questions have been answered, the patient's confidence on the treatment effectiveness will increase [3]. Only a stable therapeutic frame, where the triadic relationship among psychiatrist, patient and

drug can be read with all its meanings of refusal, escape, anger, love, manipulation, or even sexual perversion, can prevent lack of adherence. During chronic treatment, especially the one, which last years and years with subtle, but constant increasing in social skills or in the reduction of psychotic symptoms, psychiatrist may fall into a trap: the "mirage" of a complete recovery. Finally a "true relationship" between psychiatrist and his patient where drug can be expelled. A situation where the dream of recovering from a chronic serious mental illness is sustained by a chronic narcissistic omnipotence of the therapist.

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