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PSYCHODYNAMIC PSYCHOPHARMACOTHERAPY AND APPLICATION OF "BRAIN-MIND" CONCEPT

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INTRODUCTION

Neuroscientific and neuropsychiatric researches are pointing to a complex interplay between factors traditionally dichotomized as "biological" and "psychological", the two construct that are, in fact, impossible to disentangle. This is essentially what the philosopher Baruch Spinoza more than three centuries ago argued: "mind" and "brain" are not two substances, but one - variously understood in "mental" terms for some purposes, and in "physical" terms for others (Pies 2011). Nowadays there are many reasons to use the concept what Dan Stein calls "brain-mind" (Stein 2008). As he observes, the brain-mind"... is not a computational, apart from the world, passive reflector, but rather a thinking-feeling actor in the world..."

We really cannot afford anymore to view our patients in the terms of "mental" vs. "physical", "mind" vs."body", "psyche" vs. "soma", etc., and neither afford the "luxury" of supposing only one treatment method - pharmacotherapy or psychotherapy. The best available evidence suggests that each modality, or their synergistic combination, may be effective. Psychiatrists who operate from either a dogmatic psychotherapeutic paradigm or a psychopharmacological paradigm are not having access to the patient as a whole. 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. (Vlastelica 2010).

Furthermore, psychodynamic psychopharmacotherapy and "brain-mind" concept can also 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" (Jakovljević 2008).

THE ROLE OF PSYCHODYNAMIC PSYCHOPHARMACOTHERAPY

Psychotherapy is an effective treatment for many mental disorders, and it is a valuable adjunct treatment for most others. Even in cases in which medication is necessary and accepted, the evidence suggests that psychotherapy may significantly improve patient outcomes.

Psychodynamic psychopharmacology explicitly acknowledges and addresses the central role of meaning and interpersonal factors in pharmacological treatment (Mintz & Belnap 2006). This approach recognizes that many of the core discoveries of psychoanalysis (the unconscious, conflict, resistance, transference, defense) are powerful factors in complex relationship that includes patient, his/her doctor and the medication. The patient's desire to change and a positive transference to the doctor and his/her medication can mobilize profound self-healing capacities and induce placebo effects. Placebo produces real, clinically significant, and objectively measurable improvement and changes in brain activity that largely overlaps medication-induced improvements (Mayberg et al. 2002). Just as positive transference to the doctor or drug lead to positive responses, negative transference are likely to lead to negative responses, and these patients are prone to nocebo responses (Hahn 1997). Many of them who experience intolerable adverse effects to medication are nocebo responders, and many of them become treatment-resistant. Psychodynamic concept of resistance explain that many patients were unconsciously reluctant to relinquish their symptoms or were driven, for transference reasons, to resist the doctor. Defense mechanisms play important role in dynamics of resistance and vice versa (Vlastelica et al. 2005).

Psychodynamic psychopharmacotherapy helps prescribers know how to prescribe to improve outcomes, and in that way represents an integration of biological psychiatry and psychodynamic insights and techniques.

Classical psychoanalytic theory, with emphasis on concepts of resistance, transference, and countertransference, has shed some light and guided clinicians who work with patients who are nonadherent. Some helpful psychodynamic concepts include clinicians' failure of empathy that stems from an unconscious need to feel separate from our patients' distress, and their use of defenses of denial, rationalization, and isolation of affect.

Nonadherence to treatment by patients represents one of the most prevalent and important challenges to the practice of psychiatry. Alfonso (2011) emphasis shifts to understanding nonadherence using the paradigm of attachment theory. Despite treatment advances and efforts to elucidate the determinants of noncompliance to medical care, according to some researches, nonadherence remains ubiquitous in persons with chronic medical conditions (with average adherence rates of 43% to 78%) and in psychiatric cohorts (with average adherence rates of 50% to 62%) (Osterberg & Blaschke 2005, Lacro et al. 2002, Jónsdóttir et al. 2010).

Researchers in psychotherapy have made significant contributions to understanding nonadherence and tailoring interventions to improve treatment adherence (Julius et al. 2009). Psychodynamic theory is a framework that could be helpful in clarifying our understanding of nonadherence. In particular, looking at the contributions of attachment theory and research has allowed us to deepen our understanding of nonadherence. Strengthening the therapeutic alliance and fostering collaborative physician-patient relationships may result in improved adherence (Alfonso 2011).

PSYCHODYNAMICS OF NONADHERENCE

Cohen and colleagues 2001, have written extensively on the connection between early childhood trauma and nonadherence or resistance to care 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 nonadherence (Cohen et al. 2001).

Psychodynamic determinants and adaptive (and maladaptive) defenses related to nonadherence in psychiatric patients include factors as following (Cohen et al. 2001, Mintz 2009, Gabbard 2000):

- limited understanding of the illness;
- denial, rationalization, and isolation of affect;
- feeling coerced, disrespected, or infantilized by the physician;
- feeling deceived or manipulated;
- sensing that the psychiatrist is tentative or ambivalent when presenting the information.

As prescribers, our failure of empathy often stems from an unconscious need to feel separate from our patients-to defend ourselves against overwhelming distress and maintain a safe space and emotional distance-consequently, abstinence and neutrality are overemphasized. A collaborative stance promotes adherence, while paternalistic or categorical medication advice could be perceived as coercive and could result in partial or nonadherence.

ATTACHMENT CONCEPT AND NONADHERENCE

A recent focus on the interface between attachment theory and psychoanalytical theory has deepened our understanding of the psychodynamics of nonadherence. 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 (Bowlby 1969). 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 nonadherence (Ciechanowski et al. 2001).

The disruption in attachment bonds by separation, rejection, loss, inconsistent attunement, or fear 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 (availability and responsiveness) is essential to ensure secure attachments.

Wallin 2007, reports that a level of consistency was found between behavior observed in infancy and attachment styles in adulthood in up to 75% of subjects studied longitudinally. More important, research has demonstrated that many adults with histories that would predict insecure attachment behaviors have reparative experiences later in life with significant others that allow for "earned secure" attachments. Sensitivity, availability, and responsiveness are at the core of all psychotherapeutic interventions and enduring life-enhancing relationships.

As mentioned before, Ciechanowski and colleagues 2001. examined correlations between attachment styles and treatment adherence and hypothesized that certain adult attachment styles correlate with treatment adherence in the medically ill. They studied cohorts of diabetic patients in primary care clinic settings, a high-risk population because nonadherence to treatment among diabetic patients is associated with significant morbidity and mortality. The initial hypothesis was that only those with secure attachments would be treatment-adherent. They found that persons with dismissing attachment style had significantly worse glucose control.

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 2007. 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, and judicious sharing of counter-transference, to help patients be comfortable in letting others in and in being treatment collaborators. The dynamics of power struggles and control need to be clearly understood by the therapist, and a warm, collaborative, and cooperative stance is preferred to an authoritarian and detached attitude.

Psychotherapy 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.

CONCLUSION

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 nonadherences, placebo or nocebo, therapeutic alliance or treatment resistance, etc. Putting aside many of psychoanalytical concepts that can explain bad treatment outcome, empathy and attachment are those to address the problems of nonadherence to treatment.

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