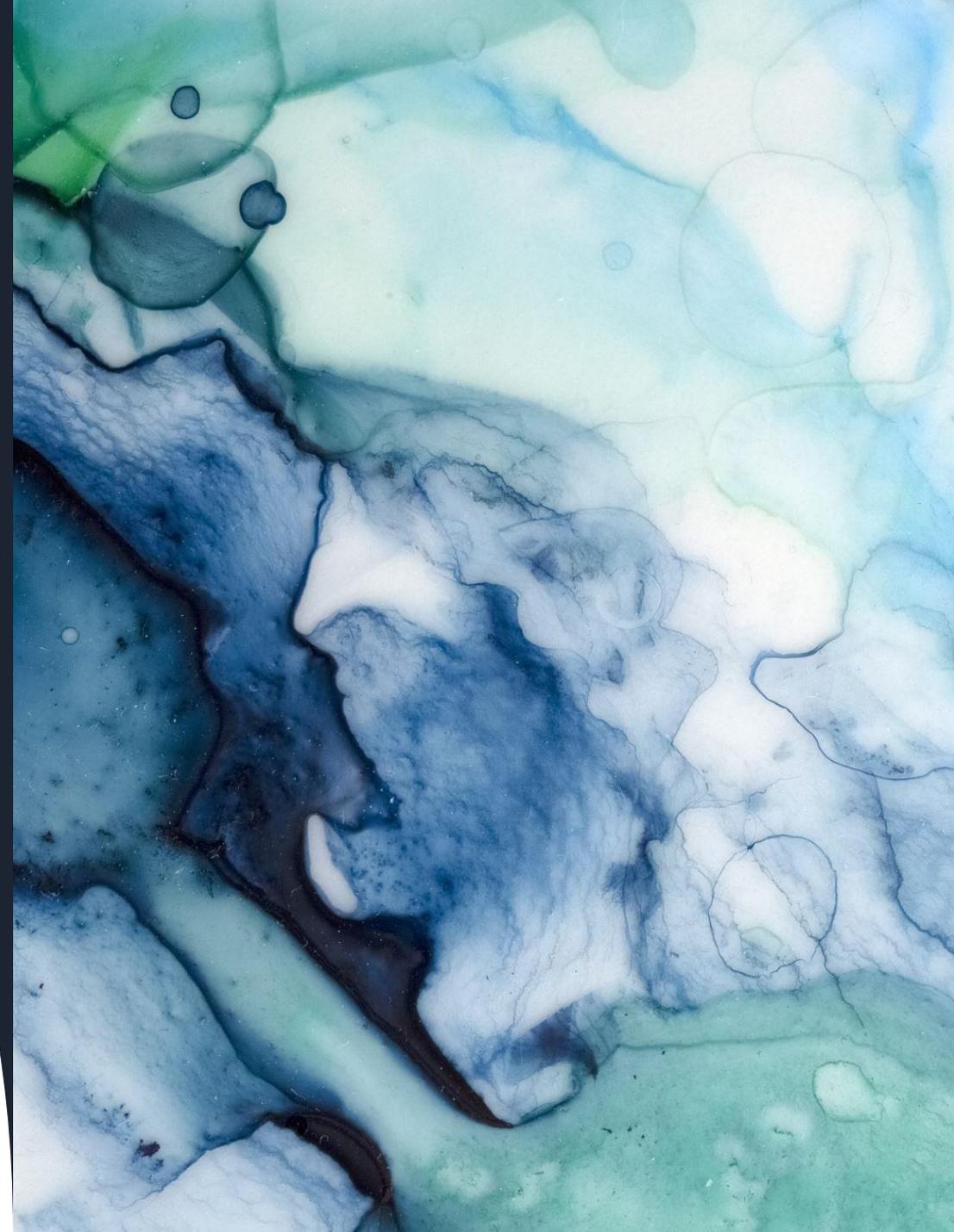


# The Psychodynamics of Pharmacologic Treatment Resistance

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# Outline

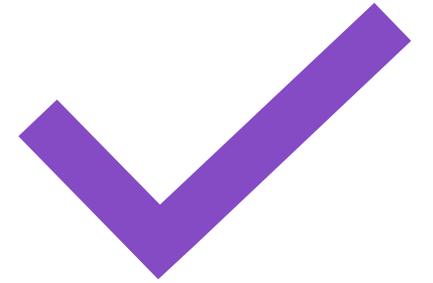
Introduction: the problems of adherence, overprescribing and deprescribing

Thinking about pharmacological treatment resistance psychologically

Types of treatment resistance

Case vignettes

Introducing a Third to the Dyad



# The significant problem with Adherence

- Adherence is different from compliance - Adherence is an active process in which a patient takes responsibility for their overall well-being, while compliance is a passive behaviour in which a patient is following a list of recommendations from the prescriber.
- Among patients with chronic illness, **approximately 50% do not take medications as prescribed**
- Clinicians often approach their work with a set of templates and internal algorithms that help them make decisions about how to respond.

# Understanding polypharmacy, overprescribing and deprescribing

- The process of managing non-beneficial or potentially harmful multiple medicines including reducing or stopping medicines, and explanations of terminology
- Overprescribing refers to situations where patients are prescribed medicines:
  - that they do not need or want
  - where potential harm outweighs the benefit of the medication
  - when a better alternative is available but not prescribed
  - where the medicine is appropriate for a condition but not the individual patient
  - when a condition changes and the medicine is no longer appropriate or required but is still prescribed

The [National Overprescribing Review](#) identified the following key points:

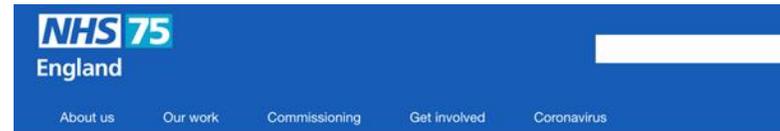
8.4m people in England are regularly prescribed 5 or more medicines

1 in 5 hospital admissions in over-65s are caused by the adverse effects of medicines

The more medicines a person takes, the higher chance there is that one or more of these medicines will have an unwanted or harmful effect.

# NHS England commissioning framework for prescribed drug dependence

- In March 2023, NHS England released a commissioning framework, including an Action to:
- ‘ensure appropriate commissioning of services for patients taking medication associated with dependence and withdrawal symptoms [including antidepressants], including services for patients wishing to reduce or stop these medications’
- <https://www.england.nhs.uk/long-read/optimising-personalised-care-for-adults-prescribed-medicines-associated-with-dependence-or-withdrawal-symptoms/>



**Optimising personalised care for adults prescribed medicines associated with dependence or withdrawal symptoms**



# Approaching treatment resistance



Review diagnosis and pharmacological treatment  
(including dose and duration of treatment)



Consider psychological factors

# Psychodynamic theory

- Meaning – conscious and unconscious
- Repetition and resistance
- Defence
- Symptoms



# Types of treatment resistance

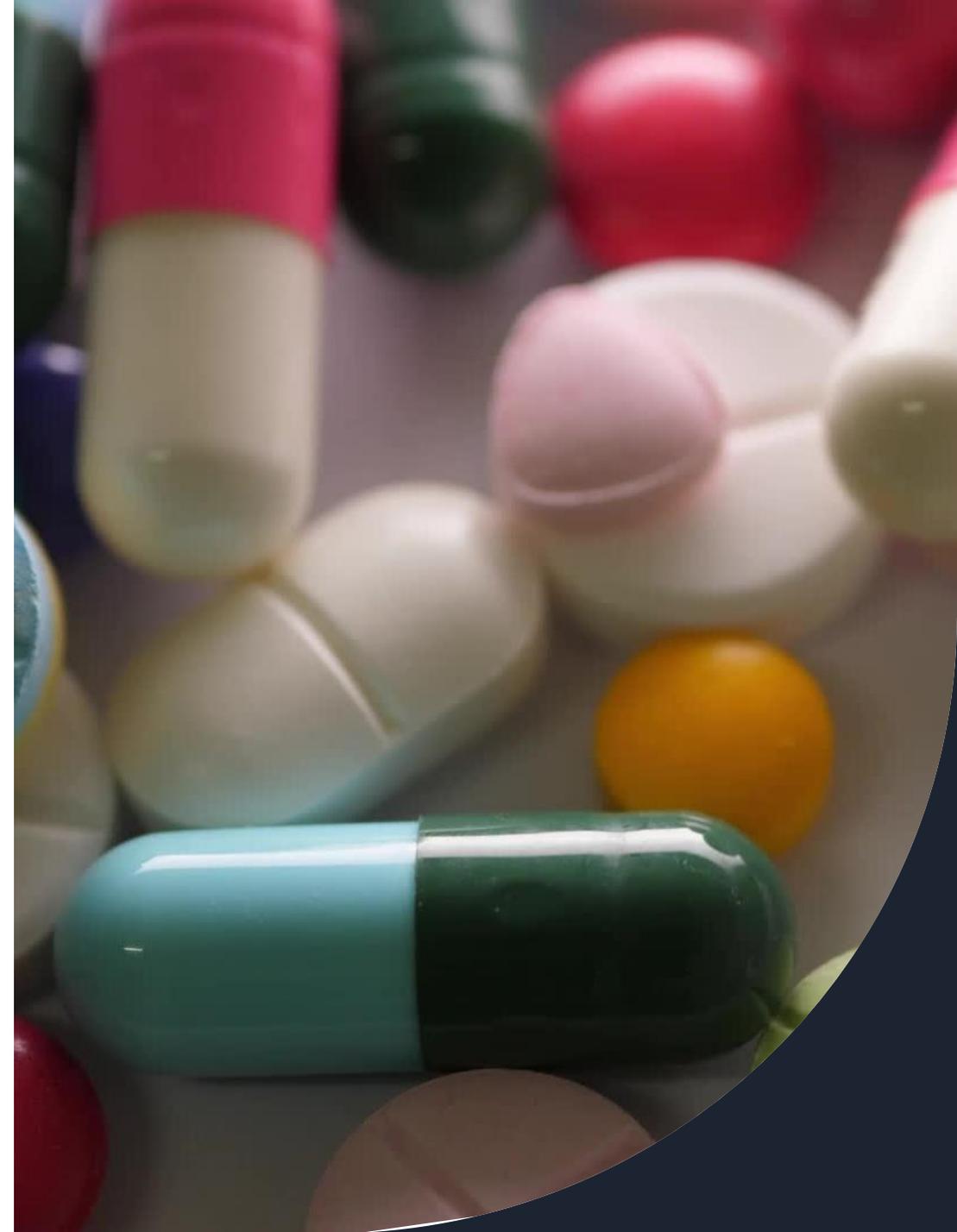
- Resistance to medication
- Resistance from medication
- Clinicians' resistance
- Systemic resistance



# Resistance to medication

- Lack of response to treatment
- Non-adherence or problematic adherence
- Side effects

Patient cannot allow the medication to have its desired effect



# Ambivalence

Why might our patients resist the treatment we prescribe?

- Ambivalence about medication
- Ambivalence about treater
- Ambivalence about illness

Acknowledge different / conflicting parts of patients (conscious and unconscious)



# Ambivalence about medication

**\* medication comes to  
represent aspects of  
patient's relational life**

Can cause physical harm

Imposition

Evidence of defect or deficit

Stigmatising

Represent dependency

Represent control by the doctor

Represent toxic / sexual intrusion

Disrupt equilibrium

## Ambivalence about treaters

Object relations  
Patient - clinician - their  
relationship - affect

Attachment  
theory

# Ambivalence about treaters

- Caregivers are unreliable
- Caregivers are out to meet their own needs
- Caregivers are harmful
- Caregivers are rejecting
- Caregivers are paternalistic or controlling
- Caregivers treat patients like symptoms



# Ambivalence about illness

Symptoms can be themselves gratifying (e.g. mania or depression)

Symptoms can be linked to secondary gains

Symptoms relieve patients of onerous responsibilities

Symptoms evoke caregiving

Symptoms can empower patients

Symptoms can serve defensive functions

Symptoms express anger to self or others

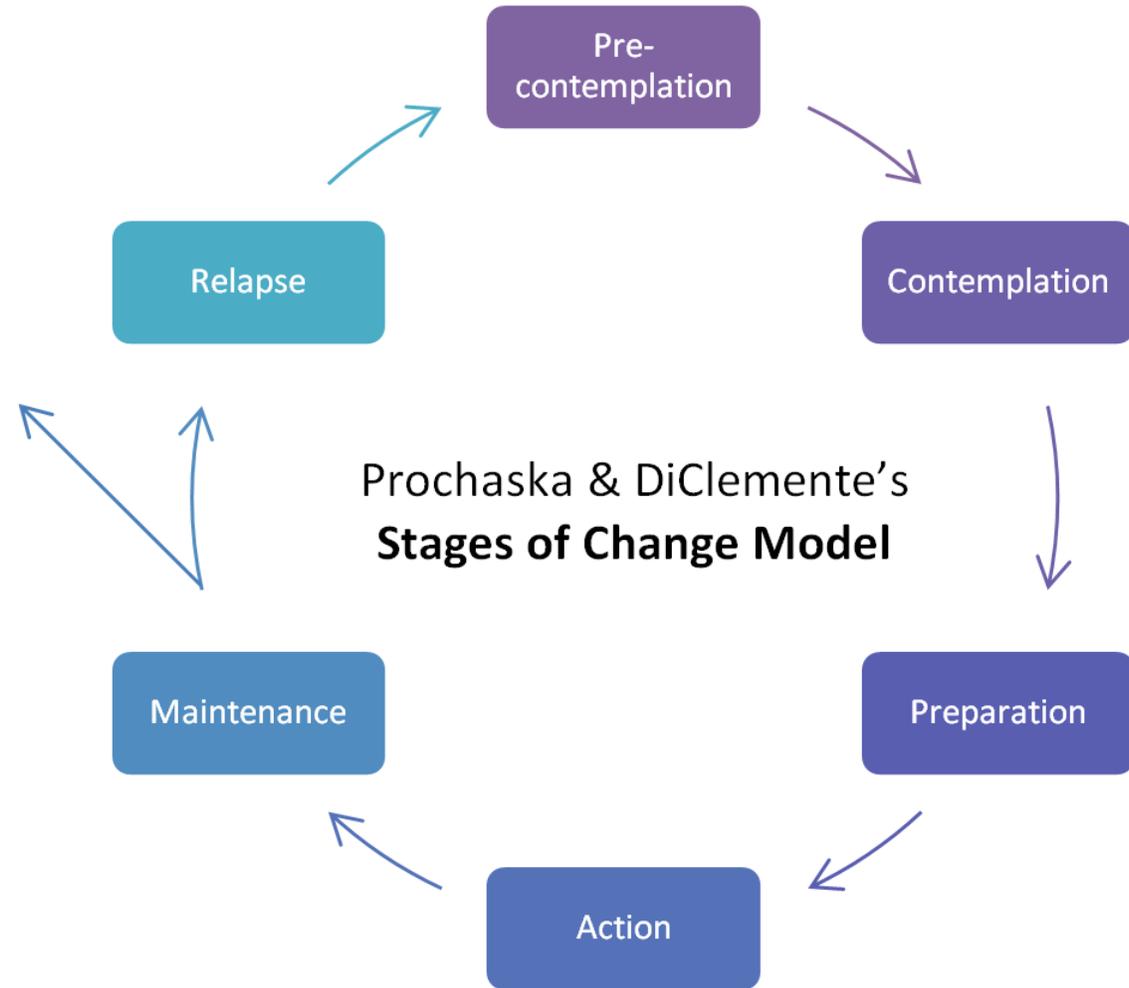
Symptoms communicate what cannot be verbalized

Symptoms as rebellion against objectification



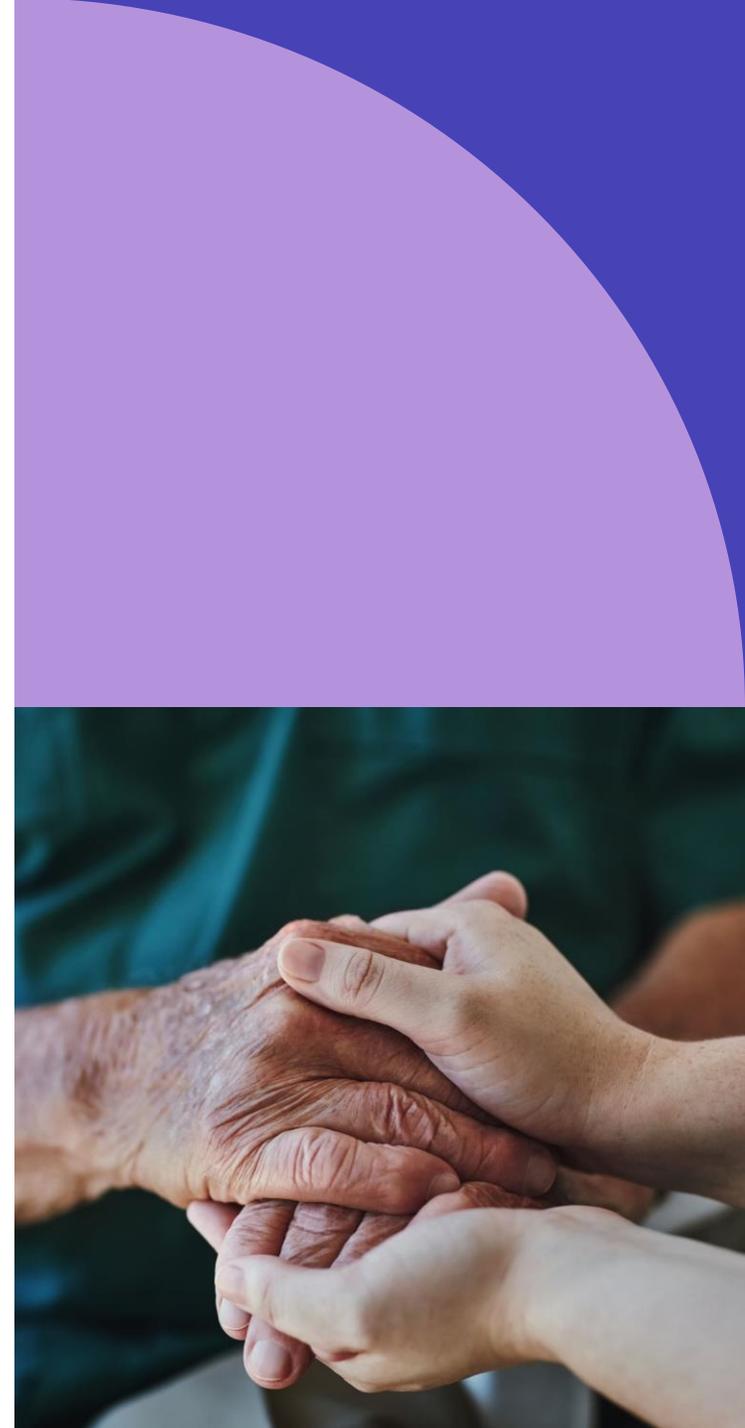
**Counter-transference?**

# Readiness to change



# Other factors to consider

- Personal and cultural beliefs
- Expectations: placebo and nocebo effect
- Treatment preference
- Family dynamics



# Case vignettes

- A 48-year old woman with a history of complex childhood trauma and chronic, debilitating non-specific pain. She has tried multiple analgesics and antidepressants. She is currently on opiate analgesics, a benzodiazepine, a z-hypnotic, a tricyclic and an SSRI. She is attached to her regular GP, but is otherwise very lonely. She complains of disturbing insomnia which she attributes to a flare up of her pain. Her doctor feels at a loss and makes a psychiatric referral.
- A 37-year old man with a history of childhood sexual abuse and OCD. He received CBT in the past and his compulsive symptoms improved, however he started being increasingly disturbed by flashbacks and nightmares. His compulsive symptoms deteriorated again a few months after he completed treatment. A number of medication trials since then have proved ineffective.

# Case vignettes

- A 40-year old business woman who suffers with recurrent depression which has not successfully responded to treatment. She has a very supportive husband. She became depressed after a miscarriage. In her background, she was a long term carer for her depressed mother who eventually committed suicide. She is on Lithium and Mirtazapine. She has passive suicidal ideation and has never made any suicide attempts. She wants to get better. She tells you that she forgets to take her tablets and her husband reminds her.

# Resistance from medication

'The person who takes medicine needs to recover twice, once from the disease, once from the medicine'

- William Osler
- Pathological attachment to medication
- Treatment itself adversely affects patient's health





## **Resistance from medication**

- Patient desires medications and reports they are effective, but they don't recover
- Medications are turned to serve countertherapeutic ends

# Resistance from medication

Emotions as signals of unmet needs

Taking medication as defence / avoidance

Biological reductionism as defence / avoidance

Prescribers as participants in the development of treatment resistance

## **Countertherapeutic uses of medication**

Medications misused in explicitly countertherapeutic ways (self-harm, recreational use)

Medications contribute to negative identity

Medications de-authorize patients

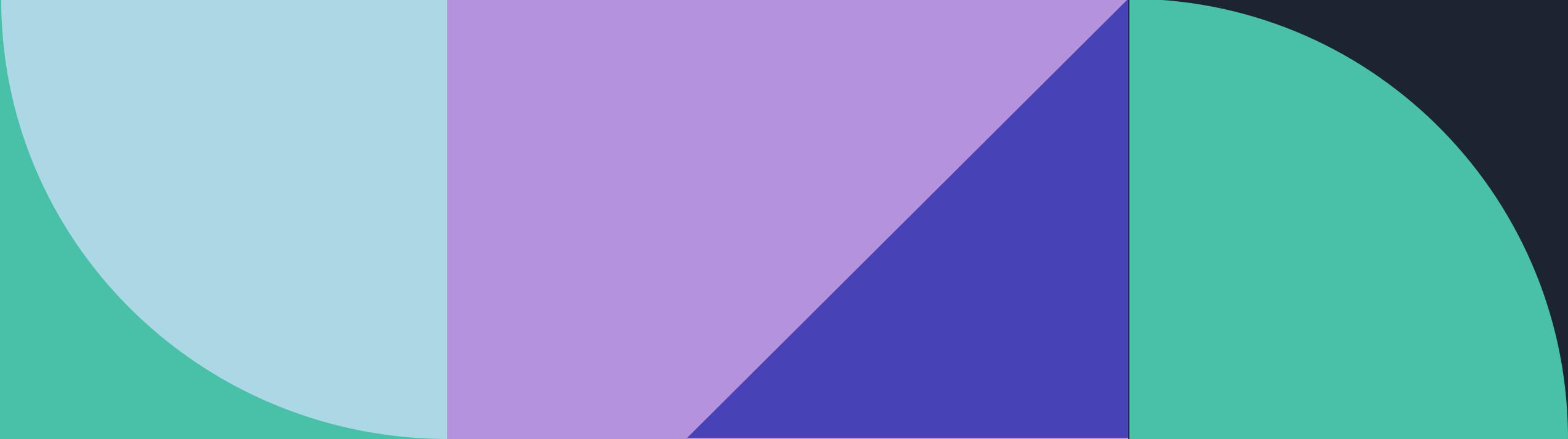
Medications de-skill patients

Medications used defensively to avoid self-awareness and responsibility

Medications used defensively to replace people

Medications used to avoid healthy developmental steps

Medication effects used to communicate experiences of harm (e.g. self-punishment)



**Counter-transference?**

# Case vignettes

- A 53-year old woman in an unhappy marriage who has struggled with depression and anxiety for many years. She doesn't have children. She had two miscarriages following IVF years ago. She has been taking an antidepressant medication for some time, which she says she has found helpful, but her daily life has remained restricted. She is asking for an additional tablet because she feels her anxiety has been worse recently.
- A socially isolated 65-year old man with recurrent depression and emotionally unstable personality traits. He is attending group therapy. The group has noticed that when he becomes aware of painful feelings, he tends to withdraw into a helpless state, physically and mentally. In the last group session, another group member indicated that he may be missing his children, whom he has alienated himself from. A few days later he asked for a psychiatric review in which he requested a change of his medication. He returned to the group after a fortnight and told the group that his psychiatrist started him on a mood stabiliser and that he feels very well, he has nothing to talk about.

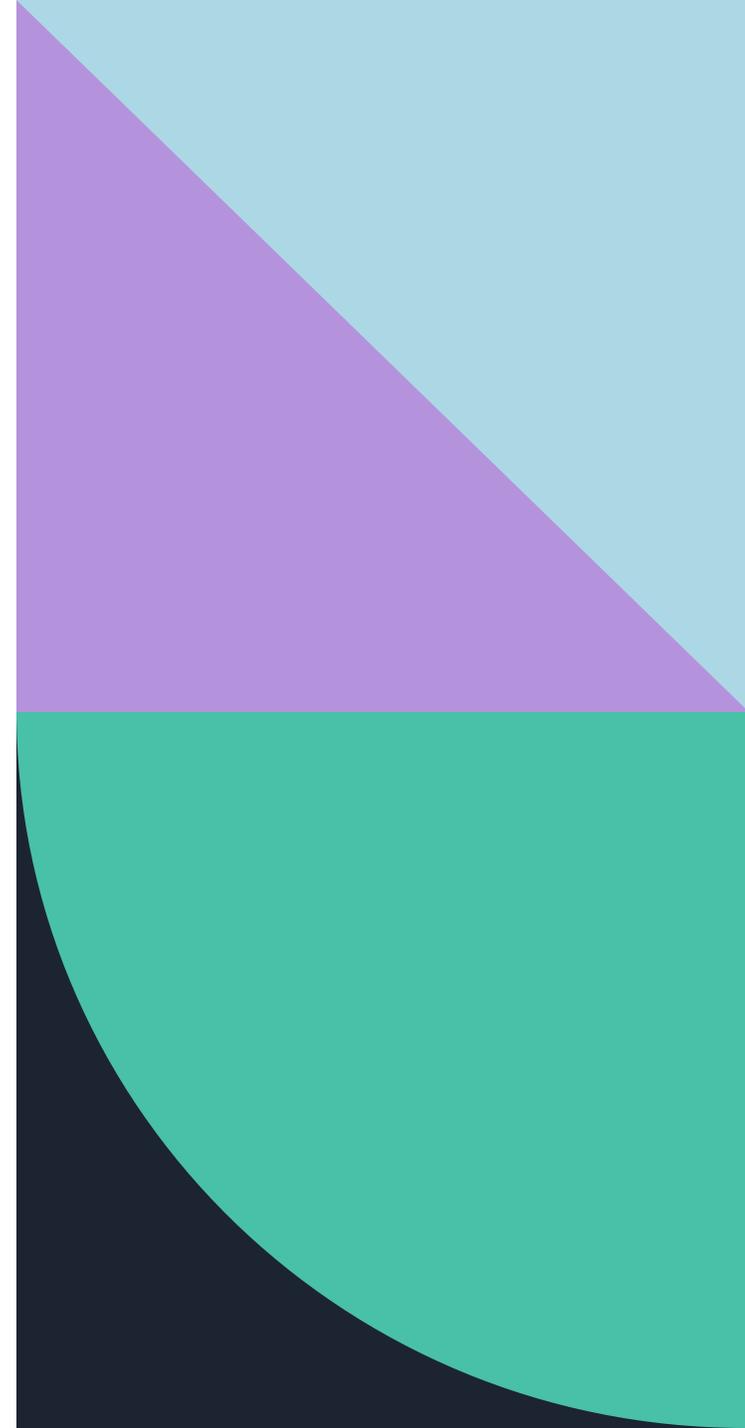
# Clinicians' resistance

- We tend to care for our patients and we want to see them get better
- Prescribing is what we trained to do and there is an expectation we do it
- We need to prove our worth and we take it as personal failure if the patient does not improve
- We do not like feeling helpless or guilty
- We feel the need to 'do' something



# Counter-transference and prescribing

- Prescribing as acting in
- Enactment of an object relationship in the act of prescribing
- Prescriber's contributions towards exacerbating negative transference
- Beware of strong feelings (or no feelings) and/or deviations from usual practice

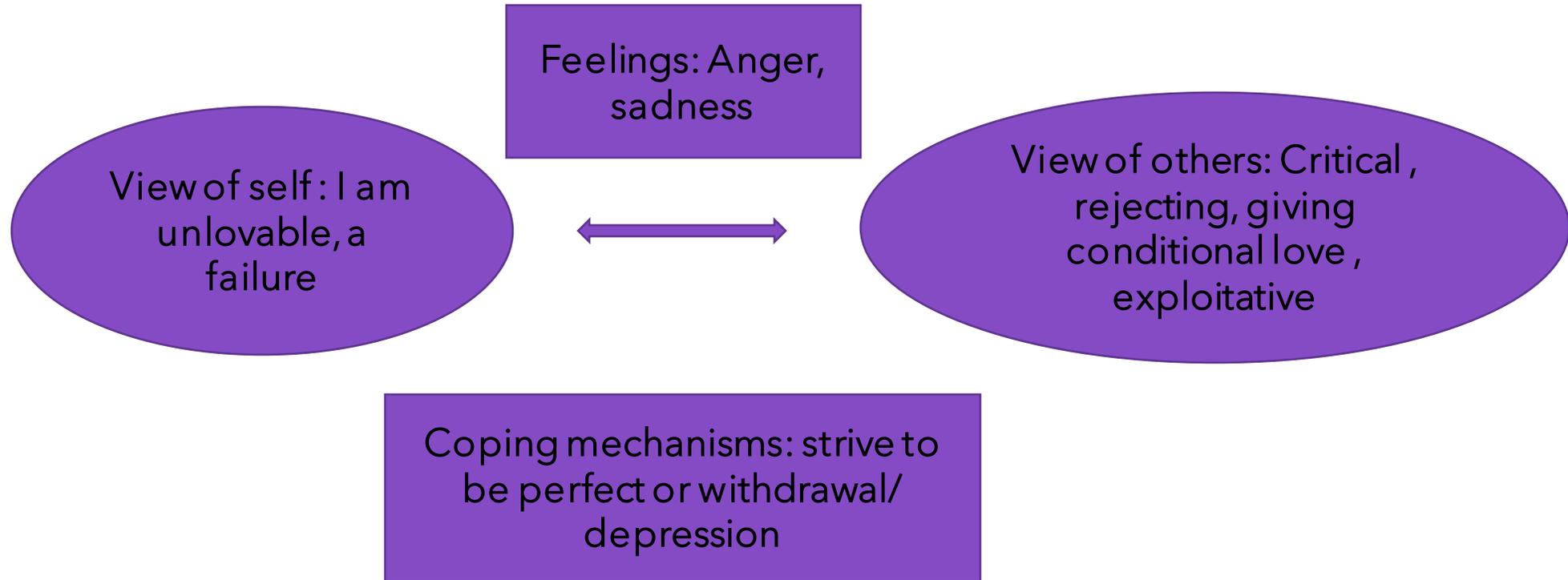


# Differentiating between therapeutic optimism and therapeutic omnipotence

'To the extent that the therapist is infected with lingering omnipotent attitudes, he will mistake the patient's wishes for realistic expectations and vainly imagine he has the obligation and the power to meet them. This, of course, he will be unable to do, and will before long find himself feeling helpless, guilty, and wishing himself far from his patient'

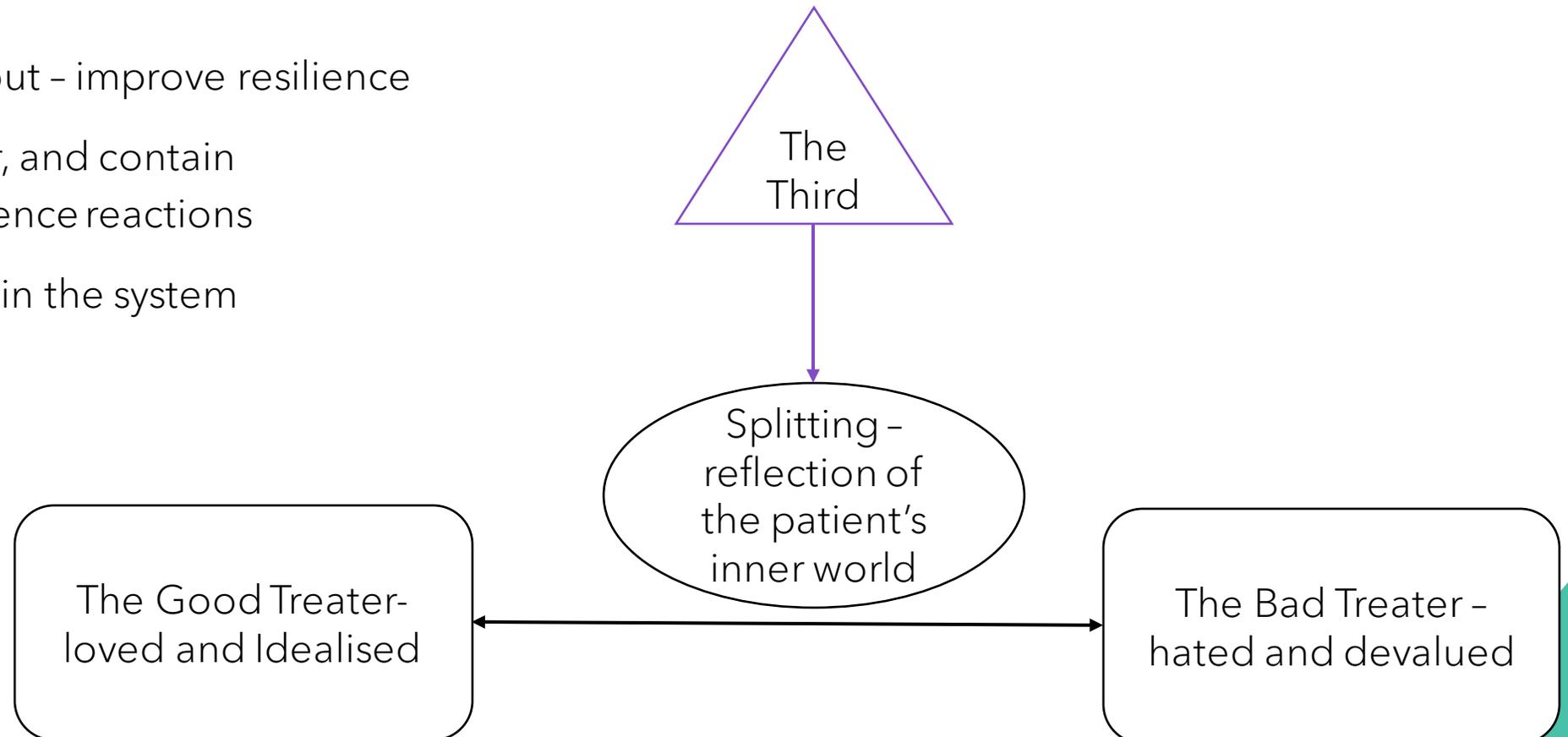
- Maltzberger & Buie 1974

# Example of an object relationship



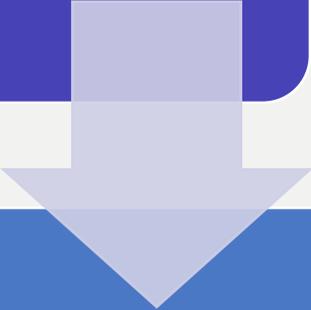
# Benefits of integrated working - managing the counter transference

- Reduced burn out - improve resilience
- Recognize, bear, and contain countertransference reactions
- Reduce tension in the system
- Improved care



# **Systemic / cultural resistance**

Operating in  
fragmented systems  
of care that defend  
against anxiety and  
uncertainty



Constant need for  
certainty,  
(re)assurance and  
solutions



Traditional medical training does not equip us to think psychologically and relationally about psychopharmacology



The guidelines can tell you what to prescribe but not how to prescribe - the relational aspect is often neglected despite the evidence



This way of working is not only helpful in treatment resistance but has important wider applications to medicines optimisation (primary care and physical health)

“Medicines cure diseases, but only doctors can cure patients.” - Carl Jung

# References

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- Mintz, D (2022). *Psychodynamic Psychopharmacology: Caring for the Treatment-Resistant Patient*, American Psychiatric Publishing, Washington DC.

**Thank you!**

