Dynamic Psychopharmacology and Treatment Adherence

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Abstract: The practice patterns of US psychiatrists have changed over the last two decades, favoring brief clinical encounters and a primary emphasis on pharmacologic care. The main focus of this paper is to illustrate the relevance of psychodynamic principles to prescribing practices. Psychodynamic aspects of pharmacotherapy will be described, including the dynamics of treatment adherence and nonadherence, medication selection, discontinuation, as well as aspects of transference and countertransference relevant to the practice of psychopharmacology. The dynamics of medication choice, underprescribing, and overprescribing will be reviewed to highlight the importance of psychodynamically informed psychopharmacology in the care of psychiatric patients. Special emphasis will be given to the contributions of attachment theorists to our understanding of treatment adherence. Psychoanalysts and dynamic psychiatrists are in a unique position to enhance psychopharmacologic case management by exploring the unconscious determinants of behavior.

Reimbursement favoring brief psychiatric visits coupled with the development of psychotropic medications that have higher tolerability and better safety profiles have changed the practice patterns of general psychiatrists, favoring psychopharmacologic case management and the division of care among physicians and nonphysician mental health clinicians. Over the past five years, having supervised the clinical psychopharmacology cases of psychiatric residents training at the New York State Psychiatric Institute/Columbia University Depart-

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ment of Psychiatry (NYSPI), I explored in psychopharmacology case management supervision the psychodynamic aspects of the doctor-patient interaction in the medication management setting, the formation of the therapeutic alliance, and how these ultimately relate to treatment adherence and outcome. A recurrent theme in psychopharmacology case management supervision is our elusive understanding of the determinants of nonadherence to medical treatment. The biopsychosocial model and psychodynamic theoretical constructs can be helpful in understanding the antecedents of nonadherence. Nonadherence to medical treatment is ubiquitous in all medical specialties, problematic, and potentially harmful. Although I will give more emphasis in this manuscript to the dynamic aspects of treatment adherence and the possible insights we may gain if we consider the contributions of attachment theory, I will also describe some dynamics of the process of medication selection, timing and discontinuation, as well as common aspects of transference and countertransference in the psychiatric practice of routine medication management.

PROFESSIONAL PRACTICE PATTERNS OF U.S. PSYCHIATRISTS

Meta-analyses of professional practice patterns of U.S. psychiatrists over the last two decades show the consistent trend that psychiatrists favor brief visits (less than 30 minutes) and endorse subspecialty emphasis on psychopharmacologic management (Olfson, Pincus, & Dial, 1994; Olfson, Marcus, & Pincus, 1999; Mojtabai and Olfson, 2008). As a result, "split treatment" has become a common mode of care, where psychiatrists practice medication management and other mental health professionals provide additional psychotherapy in separate visits. Proposed reasons for this practice trend are primarily financial: reimbursement favors brief medication management visits. Managed care reimbursement guidelines often restrict or deny reimbursement for the provision of psychotherapy by psychiatrists. Additionally, with the advent of newer and more sophisticated psychotropic drugs and somatic treatments, there has been an increase in the prescription of psychotropic medications by psychiatrists (Pincus et al., 1998). As a parallel phenomenon, psychiatric residents' education and training has shifted emphasis from development of psychotherapy skills to a more biological focus on somatic treatments. While some investigators categorically conclude that as a result of our changing practices "there has been a recent significant decline in the provision of psychotherapy by psychiatrists in the United States" (Mojtabai & Olfson, 2008, p. 962), I would like to reframe this and propose that briefer and less frequent psychi-

atric visits do not preclude the provision of psychotherapy and should not always be equated with lesser or inadequate psychotherapy (also see: Olarte, 1996; Castelnuovo-Tedesco, 1962).

The majority of psychiatrists in the U.S. work in diverse settings (average of 2.3 settings), and an average of 48 hours a week. While the majority of psychiatrists see patients in outpatient office settings, only 10% are in fulltime private practice (Olfson et al., 1994). While we comfortably navigate from one clinical setting to another, combining skill sets to help our complex patients, our views and adherence to theoretical models and models of care are often polarized and do not reflect our actual clinical practices. What we say we do and what we do may differ. What we do is often more eclectic, complex, and nuanced than what we think we do (Greenspan & Sharfstein, 1981). It is not unusual for dynamic clinicians to incorporate cognitive, behavioral, and supportive elements in their psychotherapy treatments. I believe that psychopharmacolgists can augment and improve the efficacy of, and adherence to treatment if they incorporate psychodynamic principles in their practice.

As a profession we have been experiencing a growing discomfort with "split treatment," a categorization that is, by itself, dismissive and devoid of nuances of meaning. Psychopharmacologists who attend to patients for monthly brief medication visits are also doing psychotherapy, even if the model of care followed is "medication management." Consider how primary care physicians, who meet with patients on average for less than 15 minutes a visit, sometimes as infrequently as once a year, are able to develop significant therapeutic bonds with their patients and their families over the years.

While many psychoanalysts and dynamic psychiatrists have identified the pitfalls and challenges of "split-treatment" (Michelle & Balon, 2005; Gabbard, 2006; Silvio, 2006; Busch & Sandberg, 2007), usually advocating for comprehensive holistic psychiatric care or combined psychotherapy and psychopharmacology by a physician provider as a preferred standard of care (Davidson, 2008), the reality is that split rather than integrated care has become the most common psychiatric practice in the United States (Olfson et al., 1999). Rather than focusing on conversion from one model of care to another (a battle that perhaps needs to be fought separately), I focus my supervision efforts on the realization that psychoanalytic principles can inform medication management practices. In this way, the difference between combined and integrated vs. effective split treatment may lie primarily on emphasis, quality, number of clinicians and duration of sessions, and awareness of dynamic principles. Rather than rebelling against split treatment as dangerous and fragmented, I reframe it as potentially complementary.

Some of our patients should have all the help that is available to them, and more than one clinician working together on their behalf can be advantageous, *especially* when all clinicians, including the ones who prescribe medications, are dynamically informed and work collaboratively.

Another changing paradigm is that psychiatrists (including dynamic psychiatrists and psychoanalytic physicians) are increasingly prescribing medication to their psychotherapy patients in the private practice setting. The number of patients seen in private practices receiving medication from psychiatrists increased from 44% in 1985 to 69% in 1995 (Olfson et al., 1999). A survey of my own practice in 2008 indicates that 32/40 patients or 80% of my private practice patients are taking psychotropic medication.

Psychopharmacologists and general psychiatrists who evaluate patients routinely for medication management can spend sufficient time with their patients, if not during individual sessions, certainly over time, and can incorporate psychotherapeutic dynamic principles into their routine clinical practice. In the following sections some dynamic aspects of psychopharmacologic practices will be reviewed. As Mintz (2005) poignantly stated, and I paraphrase, a dual effort should be made to better understand not only "*what* to prescribe, but also *how* to prescribe" in order to increase the clinician's efficacy as a general psychiatrist (Mintz, 2005, p. 187). Dynamic psychiatrists are in a unique position to assist in this process of professional development.

TRANSFERENCE AND COUNTERTRANSFERENCE

Medication management doctor-patient interactions, just as any other physician-patient encounter, can activate parental transferences. There is an inherent power differential in the doctor patient dyad and it is not unusual for vulnerable patients to perceive physicians as demanding, controlling, and excessively directive. Patients may regress as doctors become paternalistic, regression adding to fears of dependency. Grandiose fantasies and unrealistic wishes to rescue patients from their distress may push doctors to become eagerly overprotective resulting in overmedication. Overprescription and polypharmacy can also be fueled by the physician's negative affects and may originate in projective identifications. "Countertransference prescribing" (Mintz, 2005) may serve as a defense against anxiety and helplessness. Conversely, aggressive

overprescription can be a manifestation of devaluing psychotherapy in both split/fragmented and combined treatment settings. Psychiatrists may overprescribe when faced with a psychotherapy treatment impasse or when patients verbalize negative transferences.

"Countertransference prescribing" (Mintz, 2005) invariably works against the therapeutic alliance. Gabbard (2005) points out that patients often have the subjective experience of feeling dismissed when medication is recommended to alleviate their distress. If the physician does not make an effort to validate the patient's feelings, medication may be experienced as an anesthetic rather than as an effective tool that can provide symptomatic relief. Conversely, withholding needed medication may be a manifestation of countertransference distress.

Perry (1984) worked psychodynamically to investigate reasons for the undermedication for pain of burn victims in the New York Hospital/Cornell Burn Unit. He found that physicians' insensitivity and mistaken ideas about pain management could not adequately explain why some patients were undermedicated with analgesics. A common dynamic he observed justifying undermedication was the wish for self-object differentiation. The unconscious wish to remain separate from the patient protects the clinician defensively from the distress, despair, and helplessness experienced by patients. Undermedicating, in this way, can be understood as an attempt to delineate boundaries and prevent overidentification with patients faced with catastrophic illness or overwhelming pain.

Perry (1984) postulated that a modicum of pain in the medically ill preserves ego boundaries. Just as physicians can undermedicate, patients often show stoicism and fear being deadened or anesthetized, resisting needed medications with unconscious fears of losing their humanity, or of disintegration by relinquishing their symptoms, suffering, or distress.

Gutheil (1982) described that placebo and nocebo responses can have transference elements. Explaining the principle of a transference cure or the concept of the negative transference to a trainee in the context of a medication management situation could help crystallize their understanding of the importance and eminence of transference in doctor-patient interactions. Mintz (2005) points out that nocebo responses occur more often in persons of low socioeconomic status who have been personally victimized or socially oppressed. Prescribing to patients who have been harmed before should take place after sufficient trust is established in the therapeutic alliance.

PSYCHODYNAMIC ASPECTS OF MEDICATION SELECTION AND DISCONTINUATION

Questions that can help reframe our pharmacologic practice include: What are we prescribing medications for . . . to target symptoms, to alleviate distress, to treat an illness, or to treat a disease? How do patients' and physicians' expectations about medication differ?

Patients feel ill and report their distress using very specific language. We translate these narratives of distress into our constructs of symptom clusters, disease categories, disorders, and syndromes. Physicians reformulate patients' concerns and complaints by using the medical model, that is, etiology is at the root of symptoms, which in turn signals disease and points to specific treatments. Our reformulations have the potential to alienate patients, and by giving the impression that our language is preferred or more accurate we become dismissive rather than attentive. Deviating from our patients' descriptions and parameters may inadvertently communicate the opinion that their descriptions are inadequate, and promptly substituting their words with ours could result in failure of empathy, resistance, or disinterest in following our recommended treatments.

Compounding the complexity of adequate medication selection is the maxim that psychotropic medications can have limited specificity and limited efficacy. What we call antidepressants we may also prescribe and are equally effective for anxiety disorders. Many antipsychotics are now marketed as mood stabilizers. Second generation antipsychotics with FDA approval as mood stabilizers work best to alleviate positive symptoms of schizophrenia, minimally to treat negative symptoms of schizophrenia, modestly for acute mania, and minimally for depressive episodes. Gutheil (1982) wrote about this issue of lack of specificity of our biological treatments and how imprecise is our understanding of the neurobiology of psychopharmacology. Even with significant advances in the fields of psychopharmacology and nosology over the past decades since Gutheil's dictum of "delusions of precision," the fact remains that our understanding of phenomenology and diagnostics by far exceeds the specificity of our current somatic treatments.

Similarly, although major biological advances over the past two decades have equipped psychiatrists with a broader armamentarium of somatic treatments, the efficacy of psychotropic medications for certain psychiatric disorders is at times only slightly better than placebo (Khan et al., 2005). The efficacy of medication for conditions such as personality disorders, eating disorders, negative symptoms of schizophrenia, and some drug dependence disorders is modest at best.

A common dynamic leading to excessive polypharmacy or serial trials of diverse medications are states of shared helplessness and fear of failing our patients. A 30 year old referred to my practice for a "psychopharmacology consultation" by his psychotherapist, was symptomatic with severe depression while under the care of a reputable psychopharmacologist, on high doses of two antidepressants, a mood stabilizer, an atypical antipsychotic, a stimulant, and two hypnotic agents. The patient presented with atypical depressive features, worsened by excessive sedation and cognitive impairment caused by polypharmacy. A careful history revealed numerous failed medication trials for depression over his entire adult life, and a prominent family history of depression that included completed suicide. I advised simplifying polypharmacy with a washout period of two weeks of all medications and initiation of MAOI pharmacotherapy. After two weeks of treatment on an MAOI the patient improved with a drop of 10 points in the Montgomery Asberg depression rating scale. Polypharmacy in this case of "treatment-resistant depression" was understood in part as a function of countertransference anxiety felt by his treating clinicians due to the intensity and persistence of the patient's negative affects, as well as a reaction to shared despair and helplessness.

I encourage trainees to use psychometric scales in their practice, not for their diagnostic value but to ascertain clinical progress in a way that is tangible to both doctors and patients. I suggest introducing standardized psychometric scales in treatment not during their first clinical encounter but later on in the early phase of treatment. Sufficient time should be allowed to listen to the patients' narratives. I suggest to trainees to keep two sets of scores, one reflecting their perception of how the patient is progressing (answering the questionnaire on behalf of the patient before their clinical encounter takes place) and a separate score reflecting the actual answers the patient gives to the standardized questions asked. Almost always, as the doctor becomes more attuned with his or her patient, both sets of scores tend to approximate.

A common dynamic associated with premature medication discontinuation is denial of illness. Anger in the countertransference with help-rejecting patients or with patients who amplify symptomatic distress may also lead to premature dose reductions of medications, iatrogenic physiologic drug-withdrawal states, and premature discontinuation of treatment.

Unconscious motivations may compound the problem of lack of familiarity with treatment guidelines and deviation from consensus reports. Consider the case of an otherwise healthy patient presenting with new onset, uncomplicated panic disorder. We are familiar with the clear practice guidelines recommending a slow titration of a selective

serotonin reuptake inhibitor over 6-8 weeks, along with rapid initial titration of a benzodiazepine, followed by slow tapering of the benzodiazepine drug after a month of treatment. Patients with panic disorder feel as if they are dying. The intensity of their physiological anxiety reaction and fear of losing control often leads to resistance to the notion of letting go of the drug that is perceived as helping the most, the benzodiazepine, since its anxiolytic properties are felt immediately and clearly. In our effort not to harm our patients we may deviate from the standard of practice and keep the patient on a medication such as a benzodiazepine for an unnecessarily extended period of time, creating iatrogenic pharmacologic tolerance and dependence.

I encourage residents to tell their patients what the anticipated duration of treatment will be once the first prescription is given. We seek comfort in avoidance due to our discomfort with approximations in our scientific practice. While we may not feel comfortable predicting a wide range of duration of treatment such as "six months to two years," our patients appreciate having an approximate time frame for as long as they understand what are the variables that will determine the prescribed length of treatment.

BIOPSYCHOSOCIAL ASPECTS OF TREATMENT ADHERENCE

Blackwell's (1976) *Rule of Thirds* postulates that only one-third of patients fully adhere to prescribed treatment, one-third are partially adherent, and one-third are fully noncompliant to medical treatment. His observations have been clinically validated across all medical specialties, diverse patient populations, and transculturally. For example, in a Norwegian study of well-informed psychiatric patients, where 98% of patients knew the names of their medications and 91% knew their diagnoses, 58% admitted to noncompliance (Jensen & Holte, 1997). For centuries, physicians of all specialties have theorized about, searched and researched the determinants of nonadherence to medical treatment (Osterberg & Blaschke, 2005).

Engel's (1977/1980) biopsychosocial model can be useful in delineating and identifying possible determinants of nonadherence. Lacro, Dunn, Dolder, & Leckband, and Jeste (2002) review of reasons for nonadherence among psychiatric patients and Osterberg and Blaschke's (2005) review of the medical literature identified the following biological determinants of nonadherence: adherence more difficult in chronic than acute illness, lack of efficacy of medication, medication side effects and intolerability, latency of medication response, frequency of doses, complexity of drug regimen, and comorbid drug dependence

and addiction. Psychosocial variables that mediate nonadherence include poor discharge planning, brittle aftercare plans, lack of access to treatments, cost of care, poor doctor-patient relationship, and lack of family and social support.

Psychiatric conditions that are clearly associated with poor treatment adherence include mood disorders, psychoses, cognitive impairment, and drug dependence (Osterberg & Blaschke, 2005; Colom, et al., 2000; Cramer & Rosenheck, 1998; Lacro et al., 2002).

A recent issue of the *JAAPDP* (2007, Volume 37, Number 2) includes five articles exploring the meanings of medication and issues of compliance. Psychodynamic determinants of nonadherence may include feeling disrespected or infantilized; feeling deceived, coerced or manipulated, failure of empathy and a poor therapeutic alliance (Leeman, 2007; Rosenfield, 2007; Rubin, 2007). Cohen has written extensively on the connection between early childhood trauma and nonadherence or resistance to care in adult patients (Cohen, 1999; Cohen, Alfonso, Hoffman, Milau, & Camera, 2001; Ricart, et al., 2002), postulating that traumatized patients' sense of foreshortened future may be related to failure to engage in or accept medical treatment.

A recent focus on the interface between attachment theory and psychoanalytic theory has deepened our understanding of the multifactorial biopsychosocial aspects and psychodynamics of nonadherence. The following section summarizes some of the contributions of attachment theory and research to the understanding of the dynamics of treatment adherence.

TREATMENT ADHERENCE AND ATTACHMENT THEORY

For almost four decades attachment theorists have informed psychoanalytic practitioners, stressing the importance of how preverbal early life experiences can impact adult behavior. Most recently, clinical researchers studying the determinants of adherence have suggested that attachment theory can also deepen our understanding of the dynamic underpinnings of treatment nonadherence. After providing a brief overview of the salient concepts of attachment theory, I will review research findings correlating specific attachment styles with noncompliance to prescribed treatments in the medically ill and discuss the possible clinical implications for our general dynamic pharmacologic practice.

Attachment theory is based on the premise that early life experiences with caregivers are internalized in the form of cognitive models that determine how individuals relate to others in adulthood (Bowlby, 1973; Wallin, 2007). Attachment concepts were originally conceived to un-

derstand the evolutionary, adaptive and biological aspects of parent-infant care giving. Bowlby stressed the importance of parental physical proximity and nonverbal attunement, in addition to feeding and orality, based on his observations of children and parents and on the work of colleagues in fields of evolutionary biology and ethology (Bowlby, 1958). Bowlby formulated that disruption in attachment bonds, be it via separation, rejection, loss, inconsistent attunement, or fear could lead to problematic behavior during childhood and possibly across the life span (Bowlby, 1951, 1988).

Mary Ainsworth' systematic transcultural research and naturalistic observations in clinical laboratories in separate continents (Ainsworth, 1967; Ainsworth et al 1978) corroborated Bowlby's earlier assertions, and led to what are now known as the attachment classifications of mother-infant dyads. Like Bowlby, Ainsworth observed that sensitivity to the infant's needs, availability, and responsiveness were essential to ensure secure attachments (Ainsworth et al., 1978).

Ainsworth and colleagues observed in their laboratories infants' reactions to separation from the mother, exposure to a stranger, and reunion with the mother. They initially described three types of attachment interactions: secure, avoidant, and ambivalent. Secure infants tend to be consoled by reunion and reconnection, infants with avoidant attachment are indifferent and avoid mother when reunited, and infants with ambivalent attachment, although preoccupied with mother's whereabouts during separation are inconsolable during reunion. Secure babies have sensitive and attuned parents; avoidant babies have parents who are emotionally constricted and uncomfortable with physical contact; and ambivalent babies have parents who oscillate in their stance from available and responsive to insensitive and rageful (Ainsworth, Blehar, Waters, & Wall, 1978; Wallin, 2007, pp. 17-20). The clinical implications of Ainsworth research data classifications are important. Early life attachment dyadic or triadic interactions could determine adult behavioral patterns and personality traits. Secure attachments could result in resilient, competent, warm, and empathic individuals. Avoidant attachments have been associated with sullen, arrogant, resistant, and oppositional behavior, as well as with obsessional, narcissistic, and schizoid traits. Ambivalent attachments could result in clingy and immature behavior, as well as melodramatic and histrionic behavior (Wallin, 2007, pp. 23-24; Schore, 2002).

Mary Main's research focused on proving the intergenerational consistency of the internalized cognitive models of early life dyadic interactions (Main, Kaplan, & Cassidy, 1985; Main 2000). Main and colleagues developed the Adult Attachment Interview (AAI), a semi-structured clinical interview that explores in depth the adult subjects' recollec-

tions of the parenting they received and their memories of attachment (Hesse, 1999). The AAI is comprised of open-ended questions asked of adults to describe their recollection of early exchanges, memories of childhood experiences, and type of parenting received. The protocol for the AAI normally takes one hour to complete. The interviews are then transcribed verbatim and scored according to a manual. Responses to the scripted questions reveal narratives that fall into the same categories described by Ainsworth--secure/autonomous, dismissing/avoidant, and preoccupied/ambivalent. Although Main and colleagues' research found a level of consistency between behavior observed in infancy and outcomes in adulthood in up to 75% of subjects studied longitudinally, they also found that many adults with histories that would predict insecure attachment behaviors had indeed reparative experiences later in life with significant others that allowed for "earned secure" attachments (Hesse, 1999, 2008). The concept of earned secure attachment has obvious implications for psychotherapeutic work, in that the transformative power of psychotherapy can be understood as compensatory or complementary, the therapist internalized as a reparative caregiving figure moving the patient from insecure to secure attachment styles.

Main and colleagues' research findings and AAI transcripts illustrate the categorization of adult attachment styles--secure/autonomous, avoidant/dismissing, ambivalent/preoccupied, and disorganized/unresolved (Wallin, 2007, pp. 86-97). Secure individuals, like infants who are easily pacified and are able to readily engage in exploratory play, later behave as secure and empathic adults. In their AAI responses one finds narrative coherence and clear examples. Preoccupied individuals, like infants who are difficult to pacify upon a caregiver's return, who are clingy and push away toys, behave as adults who have poor self-esteem and are emotionally dependent on the approval of others. Preoccupied individuals give vague and rambling answers to the AAI. Dismissing individuals, like infants who do not protest when separated from parents and are indifferent to their return and inhibited at play, behave as adults who become compulsively self-reliant but are uncomfortable being close to or trusting others. The AAI narratives of dismissing individuals are characterized by a very brief discourse, gross generalizations, a paucity of examples, unsupported claims, even active contradictions, and an insistence on absence of childhood memories. Dismissing individuals idealize or devalue one or both parents but are unable to substantiate their claims.

The AAI has been used extensively in clinical research since its development in 1985. Although the AAI is considered the gold standard of attachment research measures, several self-report measures have been developed to use in large-scale studies. Influenced by Main's research

and by the development of the AAI, an abbreviated and user-friendly psychometric scale called the Relationship Questionnaire (RQ) was recently developed and validated for specificity and sensitivity (Bartholomew & Horowitz, 1991). The RQ is a self-administered scale for adults that consists of four short statements, each describing an attachment style reflecting the categorization of secure, dismissing, preoccupied, and fearful attachments. Subjects rate themselves for each category on a 7-point scale Likert scale. For example, a subject's score may appear as: Secure 7, Fearful 2, Preoccupied 1, Dismissing 3. Scores are meant to create a continuous rather than categorical measure to describe dominant attachment patterns in the individuals tested (See Table 1

Some studies have examined how adult attachment style could predict willingness to pursue psychotherapy or resistance to the therapeutic alliance. Dozier (1990) first posited that while individuals with secure attachment engage well in treatment, those with preoccupied attachment become clingy, needy and dependent and those with dismissing attachment deny need for help and resist care. Psychotherapy outcome studies, however, show that dismissing/avoidant individuals actually respond better to psychodynamic psychotherapy interventions than preoccupied individuals (Fonagy et al., 1996; Daniel, 2006). Fonagy's findings of a positive treatment response by dismissing patients have important implications for the psychotherapy of nonadherent or treatment resistant patients. Dismissing patients, while initially unable to remember, describe, emote, or reconstruct experiences, can be gradually exposed to these processes by a psychoanalytically informed therapist (Fonagy, 1996).

Attachment researchers have recently examined correlations between attachment styles and treatment adherence and nonadherence. Ciechanowski and colleagues (Ciechanowski, Katon, Russo, & Walker, 2001; Ciechanowski et al., 2004, 2006) at the University of Washington hypothesized that certain adult attachment styles could correlate with treatment adherence in the medically ill. Their research took advantage of the easily administered RQ (Bartholomew & Horowitz, 1991) psychometric scale in sampling thousands of subjects in order to correlate attachment styles with compliance to medical care and self-care in populations of medically ill patients.

Ciechanowski and colleagues' (2001) first published report is from a cohort of diabetic patients in a primary care clinic setting, a high-risk population since nonadherence to treatment among diabetics is associated with significant morbidity and mortality. Of 367 patients studied they found that those with dismissing attachment style had significantly worse glucose control than those with secure, preoccupied or fearful attachment styles. In this and subsequent studies the only attachment

TABLE 1. The Relationship Questionnaire (RQ)

Please rate each of the following relationship styles according to the extent to which you think each description corresponds to your general relationship style:

A. It is relatively easy for me to become emotionally close to others. I am comfortable depending on others and having others depend on me. I don't worry about being alone or having others not accept me.

B. I am somewhat uncomfortable getting close to others. I want emotionally close relationships, but I find it difficult to trust others completely, or to depend on them. I sometimes worry that I will be hurt if I allow myself to become too close to others.

C. I want to be completely emotionally intimate with others, but I often find that others are reluctant to get as close as I would like. I am uncomfortable being without close relationships, but I sometimes worry that others don't value me as much as I value them.

D. I am comfortable without close emotional relationships. It is very important to me to feel independent and self-sufficient, and I prefer not to depend on others or have others depend on me.

Note. Adapted from Bartholomew and Horowitz (1991). Scored along a 7-point Likert Scale, where 1 = not at all like me, 4 = somewhat like me, and 7 = very much like me. A = Secure attachment style; B = Fearful attachment style; C = Preoccupied attachment style and D = Dismissing attachment style.

style that consistently and significantly correlated with nonadherence to medical treatment was dismissing attachment.

Ciechanowski and colleagues' (2004) published data examined results from over 4000 subjects, also a cohort of diabetic primary care patients. Again, dismissing attachment style was associated with nonadherence to medication, lower levels of exercise, foot care, diet, and higher levels of smoking. The prevalence rates for secure, dismissing, preoccupied, and fearful attachment styles were 44%, 36%, 8%, and 12%, respectively. Although most persons in the general population have secure attachment styles, up to one-third of all people demonstrate a predominant dismissing attachment style.

Ciechanowski's (2006) published data looked at major depression as a potential effect modifier. In nondepressed patients, dismissing attachment was significantly correlated with nonadherence (missed appointments) in a sample of over 3,000 diabetic outpatients. Among depressed patients, there was no significant correlation between attachment style and adherence to care, but there was a significant correlation between depression and nonadherence.

Although it may be premature to extrapolate from these findings and conclude that dismissing attachment style, which is prevalent in roughly one-third of adults (reminiscent of Blackwell's rule of thirds), clinically correlates with nonadherence in other populations, the results of these studies call for additional research in other primary care and psychiatric cohorts in order to further study this question.

While adults with secure attachment experienced consistently responsive caregiving, adults with dismissing attachment had avoidant parents who were consistently emotionally unresponsive. Adults with secure attachment are comfortable depending on, and are readily comforted by, others. Adults with dismissing style become compulsively self-reliant, describe themselves as independent and self-sufficient, and are uncomfortable being close to or trusting 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" (p. 211). In the early stages of treatment with these individuals, he encourages a keen awareness of subtle affective cues and nonverbal communication, and even judicious sharing of countertransference. 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 (Wallin, 2007, pp. 211-223).

Collaborative decision-making is a necessary stance when working with dismissing persons who overvalue self-reliance. Relinquishing control and paternalistic attitudes while being consistently emotionally responsive to our patients who are either nonadherent or at risk for nonadherence may expedite the movement from insecure to secure attachments in the doctor-patient reparative dyad.

CONCLUSION

Psychodynamic principles can inform the practice and improve the efficacy of psychopharmacologic case management. Parental transferences can be reenacted in doctor-patient dyads, leading to undermedication, overprescription, and deviation from practice guidelines. The biopsychosocial antecedents of treatment adherence are complex and multifactorial. Psychodynamic determinants of nonadherence, in addition to having transference elements, are based on the quality of the therapeutic alliance. Attachment theorists have contributed to our understanding of the dynamics of nonadherence, and attachment research findings postulate that dismissing attachment style correlates with nonadherence to care.

The clinical implications of Attachment Theory research underscore the importance of eliciting detailed information about early life experiences. Attachment theoretical concepts provide a framework for understanding the impact of parent-infant caregiving on development and subsequent adult patterns of relationships. Psychotherapy interven-

tions based on attachment theory for parents with insecure caregiving styles can promote parental sensitivity and secure attachment organization. Similarly, psychotherapy interventions informed by the contributions of attachment theory could help adults with dismissing attachment behaviors receiving pharmacologic care who are nonadherent to treatment by stressing the importance of collaborative relationships, relinquishing excessive self-reliance and control, and promoting trust.

REFERENCES

Ainsworth, M. D. S. (1967). *Infancy in Uganda: Infant care and the growth of love*. Baltimore, MD: Johns Hopkins University Press.

Ainsworth, M. D. S., Blehar, M. C., Waters, E., & Wall, S. (1978). *Patterns of attachment: A psychological study of the Strange Situation*. Hillsdale, NJ: Erlbaum.

Bartholomew, K., & Horowitz, L. M. (1991). Attachment styles among young adults: A test of a four-category model. *Journal of Personality and Social Psychology, 61,* 226-244.

Blackwell, B. (1976). Treatment adherence. *British Journal of Psychiatry*, *129*(6), 513-531.

Book, H. E. (1987). Some psychodynamics of noncompliance. *Canadian Journal of Psychiatry, 32,* 115-117.

Bowlby, J. (1951). *Maternal care and mental health* (WHO Monograph No. 2) Geneva: World Health Organization.

Bowlby, J. (1958). The nature of the child's tie to his mother. *International Journal of Psychoanalysis*, *41*, 1-25.

Bowlby, J. (1973). *Attachment and loss: Vol. 2. Separation: Anxiety and anger*. New York: Basic Books.

Bowlby, J. (1988). *A secure base: Parent-child attachment and healthy human development*. New York: Basic Books.

Busch, F. N., & Sandberg, L. S. (2007). *Psychotherapy and medication: The challenge of integration*. Hillsdale, NJ: Analytic Press.

Castelnuovo-Tedesco, P. (1962). The 20-minute "hour": An experiment in medical education. *New England Journal of Medicine*, *266*, 283-289.

Ciechanowski, P. S., Katon, W. J., Russo, J. E., & Walker, E. A. (2001). The patient-provider relationship: Attachment theory and adherence to treatment in diabetes. *The American Journal of Psychiatry*, *158*(1), 29-35.

Ciechanowski, P. S., Russo, J. E., Katon, W. J., Von Korff, M., Ludman, E., Lin, E., et al. (2004). Influence of patient attachment style on self-care and outcomes in diabetes. *Psychosomatic Medicine,* 66, 720-728.

Ciechanowski, P. S., Russo, J. E., Katon, W. J., Simon, G., Ludman, E. , Von Korff, M., Young, B., & Lin, E. (2006). Where is the patient? The association of psychosocial factors and missed primary care appointments in patients with diabetes. *General Hospital Psychiatry, 28*(1), 9-17.

Cohen, M. A. (1999). Psychodynamic psychotherapy in an AIDS nursing home. *Journal of the American Academy of Psychoanalysis*, *27*(1), 121-133.

Cohen, M. A., Alfonso, C. A., Hoffman, R. G., Milau, V., & Carrera, G. (2001). The im-

pact of PTSD on treatment adherence in persons with HIV infection. *General Hospital Psychiatry, 23*, 294-296.

Colom, F., Vieta, E., Martinez-Aran, A., Reinares, M., Benabarre, A., & Gasto, C. (2000). Clinical factors associated with treatment noncompliance in euthymic bipolar patients. *Journal of Clinical Psychiatry*, *61*, 549-555.

Cramer, J. A., & Rosenheck, R. (1998). Compliance with medication regimens for mental and physical disorders. *Psychiatric Services, 49,* 196-201.

Daniel, S. I. F. (2006). Adult attachment patterns and individual psychotherapy: A review. *Clinical Psychology Review*, *26*, 968-984.

Davidson, L. (2008). Opinion: Medication mismanagement. *Academy Forum*, *52*, 10-12.

Dozier, M. (1990). Attachment organization and treatment use for adults with serious psychopathological disorders. *Development and Psychopathology, 2,* 47-60.

Engel, G. (1977). The need for a new medical model: A challenge for biomedicine. *Science, 196,* 129-136.

Engel, G. (1980). The clinical application of the biopsychosocial model. *American Journal of Psychiatry*, *137*, 535-544.

Fonagy, P., Leigh, T., Steele, M., Steele, H., Kennedy, R., & Matoon, G. (1996). The relation of attachment status, psychiatric classification, and response to psychotherapy. *Journal of Consulting and Clinical Psychology, 64,* 22-31.

Gabbard, G. O. (2006). The rationale for combining medication and psychotherapy. *Psychiatric Annals, 36*(5), 315-319.

Gabbard, G. O. (2005). *Psychodynamic psychiatry in clinical practice* (pp. 143-151). Washington, DC: American Psychiatric Publishing Press.

Greenspan, S. I., & Sharfstein, S. S. (1981). Efficacy of psychotherapy. Asking the right questions. *Archives of General Psychiatry, 38*(11), 1213-1219.

Gutheil, T. G. (1982). The psychology of psychopharmacology. *Bulletin of the Menninger Clinic, 46,* 321-330.

Hesse, E. (1999). The adult attachment interview: Historical and current perspectives. In J. Cassidy & P. R Shaver (Eds.), *Handbook of attachment: Theory, research, and clinical applications* (pp. 395-433). New York: Guilford Press.

Hesse, E. (2008). The Adult Attachment Interview— Protocol, method of analysis, and empirical studies. In J. Cassidy & P. R. Shaver (Eds.), *Handbook of attachment: Theory, research and clinical applications* (pp. 552-598). New York: Guilford Press.

Khan, A., Kolts, R. L., Rapaport, M. H., Krishnan, K. R., Brodhead, A. E., & Browns, W. A. (2005). Magnitude of placebo response and drug-placebo differences across psychiatric disorders. *Psychological Medicine*, *35*(5), 743-749.

Lacro, J. P., Dunn, L. B., Dolder, C. R., Leckband, S. G., & Jeste, D. V. (2002). Prevalence and risk factors for medication nonadherence in patients with schizophrenia. *Journal of Clinical Psychiatry, 63,* 892-909.

Leeman, E. (2007). The costs of compliance. *Journal of the American Academy of Psychoanalysis and Dynamic Psychiatry*, *35*(2), 179-187.

Main, M., Kaplan, N., & Cassidy, J. (1985). Security in infancy, childhood, and adulthood: A move to the level of representation. *Monographs of the Society for Research in Child Development*, *50*(1-2), 66-104.

Main, M. (2000). The organized categories of infant, child and adult attachment: Flexible vs. inflexible attention under attachment related stress. *Journal of the American Psychoanalytic Association*, *48*(4), 1055-1096.

Michelle, B., & Balon, R. (2005). *Competency in combining pharmacotherapy and psychotherapy: Integrated and split treatment*. Washington, DC: American Psychiatric Publishing, Inc.

Mintz, D. (2005). The psychology of psychopharmacology. *Academic Psychiatry*, *29*, 187-194.

Mojtabai, R., & Olfson, M. (2008). National trends in psychotherapy by office-based psychiatrists. *Archives of General Psychiatry*, *65*(8), 962-970.

Olarte, S. W. (1996). The medical psychoanalyst in time of change: The utility of PRN therapy. *Journal of the American Academy of Psychoanalysis*, *24*(3), 445-456.

Olfson, M., Pincus, H. A., & Dial, T. H. (1994). Professional practice patterns of U.S. psychiatrists. *American Journal of Psychiatry*, *151,* 89-95.

Olfson, M., Marcus, S. C., & Pincus, H. A. (1999). Trends in office-based psychiatric practice. *American Journal of Psychiatry*, *156*(3), 451-457.

Osterberg, l., & Blaschke, T. (2005). Adherence to medication. *New England Journal of Medicine, 353*, 487-497.

Perry, S. (1984). Undermedication for pain on a burn unit. *General Hospital Psychiatry*, *6*(4), 308-316.

Pincus, H. A., Tanielian, T. L., Marcus, S. C., Zarin, D. A., Thompson, J., & Magno Zito, J. (1998). Prescribing trends of psychotropic medications: Primary care, psychiatry and other medical specialties. *Journal of the American Medical Association*, *279*(7), 526-531.

Ricart, F., Cohen, M. A., Alfonso, C. A., Hoffman, R. G., Quinones, N., Cohen, A., & Indyk, D. (2002). Understanding the psychodynamics of nonadherence to medical treatment in persons with HIV infection. *General Hospital Psychiatry, 24*(3), 176-180.

Rosenfield, P. J. (2007). Poison or cure: Meanings of medication in schizophrenia. *Journal of the American Academy of Psychoanalysis and Dynamic Psychiatry*, *35*(2), 189-201.

Rubin, J. (2007). Be careful what you wish for: Going beyond compliance. *Journal of the American Academy of Psychoanalysis and Dynamic Psychiatry*, *35*(2), 203-210.

Schore, A. (2002). Advances in neuropsychoanalysis, attachment theory, and trauma research: Implications for self-psychology. *Psychoanalytic Inquiry*, *22*, 433-484.

Silvio, J. R. (2006). Review of *Competency in combining pharmacotherapy and psychotherapy: Integrated and split treatment*, *The Journal of the American Academy of Psychoanalysis and Dynamic Psychiatry*, *34*(1), 228-230.

Jensen, K., & Holte, A. (1997). *Tidsskrift for Norsk Psykologforening*, *34*(5), 387-393.

Wallin, D. J. (2007). *Attachment in psychotherapy.* New York: Guilford.

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