Understanding the Psychodynamics of Nonadherence

by César A. Alfonse, MD

Nonadherence to treatment by patients represents one of the most prevalent and important challenges to the practice of psychiatry. Despite treatment advances and efforts to elucidate the determinants of noncompliance to medical care, 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%).1 Researchers in cognitive-behavioral therapy, psychoeducation, and motivational interviewing have made significant contributions to understanding nonadherence and tailoring interventions to improve treatment adherence.1 A psychodynamic theoretical framework is another approach to understanding and improving adherence.

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.1 Strengthening the therapeutic alliance and fostering collaborative physician-patient relationships may result in improved adherence.

Psychological and psychodynamic antecedents of nonadherence

Cohen and colleagues2 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.

Psychodynamic theorists and adaptive (and maladaptive) defenses related to nonadherence in psychiatric patients include3:4

- 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.1 A collaborative stance promotes adherence, while paternalistic or categorical medical advice could be perceived as coercive and could result in partial or nonadherence.
Attachment theory and nonadherence

A recent focus on the interface between attachment theory and psychoanalytic theory has deepened our understanding of the psychodynamics of nonadherence. Attachment theory is based on the premise that early life experiences with caregivers are internalized and determine how individuals relate to others in adulthood. 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.1-13

The disruption in attachment bonds by separation, rejection, loss, inconsistent attachment, 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 and lead to an empirically based classification of mother-infant dyads. Ainsworth and colleagues14 observed in their laboratories infants’ reactions to separation from the mother, exposure to a stranger, and reunion with the mother. They initially described 5 types of attachment interactions: secure, avoidant, and ambivalent. Secure infants are soothed by reunion and reconnection with the mother; infants with avoidant attachment are indifferent and avoid the mother when reunited; and infants with ambivalent attachment, although comforted by the mother’s whereabouts during separation, are inconsolable during reunion. Secure infants have sensitive and attuned parents; avoidant infants have parents who are emotionally constrained and uncomfortable with physical contact; and ambivalent infants have parents who oscillate in their stance from available and responsive to insensitive and rageful.15,16

Ciechanowski and colleagues17-19 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. However, the findings were surprising and indicate that attachment style correlates with nonadherence. 1 correlates with adherence, and 2 are not significant. They found that persons with dismissing attachment style had significantly worse glucose control than those with secure, preoccupied, or fearful attachment styles. Dismissing individuals, such as infants who do not protest when separated from parents and who are indifferent to their return and are inhabited by play, as adults become compulsively self-reliant and are uncomfortable being close to or trusting of others. 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. They idealize or devalue one or both parents but are usually unable to substantiate their claims. Adults with secure attachment experienced consistently responsive relationships.20-22

Caring for parents, while adults with dismissing attachment had avoidant parents who were consistently emotionally unresponsive. Adults with secure attachment are comfortable among 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. Dismissing patients, while initially unable to remember, describe, emulate, or reconstruct experiences, can be gradually exposed to these processes by a psychodynamically informed therapist.

What is already known about the psychodynamics of nonadherence?

Classical psychoanalytic theory, with emphasis on concepts of resistance, transfer, 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.

What new information does this article add?

In this article, emphasis shifts to understanding nonadherence using the paradigm of attachment theory.

What are the implications for psychiatric practice?

Identifying adults with dismissing attachment style can be predictive of nonadherence to care. Dismissing individuals are compulsively self-reliant and tend to idealize or devalue with facility, but they can be easily engaged in psychotherapy and are open to the possibility of ‘‘earned attachment’’ through collaborative, nonfrontal psychotherapeutic interventions.

Therapeutic implications

Awareness of dismissing attachment behaviors in our nonadherent patients can help us reframe our psychotherapeutic work. Wallin23 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 communica- tion, and judicious sharing of countertransference, 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 under- stood by the therapist, and a warm, collaborative, and cooperative stance is preferred to an authoritarian and detached attitude. Attachment theory and research provides a useful framework for understanding the impact of parent-infant caregiving on development and subsequent adult patterns of relationships. Psychotherapy interventions 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 who are nonadherent to treatment by stressing the importance of collaborative relationships, relinquishing excessive self-reliance and control, and promoting trust.

Dr Alfonso is president (2010-2012) of the American Academy of Psychoanalysis and Dynamic Psychiatry (AAPDP). The AAPDP’s 55th Annual Meeting will take place May 12-14, 2011, in Honolulu. The meeting’s theme is ‘‘Psychodynamic Approaches to Treatment Resistance and Therapeutic Obstacles.’’ Dr Alfonso reports that he has no conflicts of interest concerning the subject matter of this article.

References