2. The role of the psychiatrist in improving patient compliance

Ljubomir Hotujac

Key words: psychiatric patients; compliance; doctor's role

Summary

Compliance, usually referring to how well the patient takes the medication as prescribed, is an important issue in clinical practice. However, many patients, especially those with a psychiatric illness, stop taking their medications despite physician advice to continue. This cessation can lead to a deterioration in the condition, a relapse, or a recurrence of the illness. In the literature, many different factors contributing to poor compliance have been described, but the doctor's role and responsibilities are hardly mentioned. These factors will be discussed here with special emphasis on what a doctor should do and what a doctor should avoid.

2.1. Introduction

According to Fawcett [Fawcett, 1995], compliance usually means the extent to which the patient takes the medication as prescribed. Many psychiatric patients should take their medications for several months or years. Some patients must continue taking medication throughout their lives. Usually, the recommended treatment period for a first episode of depression is 6 to 12 months, but almost half of patients stop taking their antidepressant therapy too soon [Lin et al, 1995]. Such harmful practices can have serious conse-

quences, such as deterioration, relapse, or recurrence of the illness. Therefore, enhancing medication compliance is an important treatment goal for patients and clinicians.

Fawcett [Fawcett, 1995] described five groups of factors that may affect patient compliance with taking medications:

- patient characteristics (e.g., attitudes toward illness and medication, socioeconomic considerations, social supervision);
- the treatment setting (e.g., primary care versus specialty office and inpatient versus outpatient);
- medication characteristics (e.g., side-effects, individual sensitivity to side-effects, simple versus complicated medication regime);
- clinical features of the disorder (e.g., chronicity, exaggerated feelings of guilt in depression, suspiciousness in schizophrenia, substance abuse, and comorbid anxiety); and
- clinician expertise (e.g., knowledge of pharmacology, empathy, skills of instilling hope, successful integration of pharmacology and psychotherapy).

In addition to ceasing intake of medications against the physician's advice, non-compliance or nonadherence can take other forms. Salzman [Salzman, 1995], for example, identified three such common forms of treatment nonadherence in the elderly: overuse and abuse of medications, forgetting, and alteration of schedules and doses. Overuse of prescribed drugs could lead to emergence of or an increase in side-effects.

We have definitely entered a period of availability of particularly effective medications for various diseases in various fields of medicine. However, we are confronted with the phenomenon of patient nonadherence to recommendations for taking drugs, which results in numerous consequences for the course of the disease and the patient's health. Nonadherence happens in almost all fields of medicine, such as in the treatment of hypertension and tuberculosis [Johnson et al, 1999; Menzies et al, 1993] or among women taking contraceptive pills, but it is probably most frequent in the field of psychiatry because of specific factors related to psychiatric patients.

In the treatment of psychotic disorders, it is possible to distinguish three periods of adherence: period of obedience, period of compliance, and period of cooperation (alliance).

2.2. Period of obedience: ancient history

We can nostalgically ruminate on long-gone times, an era of magic medicine when the then-physician—a witch doctor—was the only accepted and acknowledged mediator between evil forces causing illness and disaster and those bringing health and prosperity. Under such conditions, the patient had no choice. The authority of the person providing physic and the awe that person inspired left no room for disobedience regarding "therapy" prescribed by the then-"doctor". In modern terminology, we could say that at that time, adherence was high.

2.3. Period of compliance: current era

In modern times, the doctor–patient relationship has changed. The news media increasingly report on physician errors with fatal consequences (such as the non-recognition of a posttraumatic aortal rupture that led to death 15 days later or an untimely caesarean section that caused a newborn's death). The publicity given to physician error can ultimately be positive because it motivates doctors to approach patients with particular attention, care, and knowledge and ensures that negligence and errors lead to painful investigations and severe consequences. The sequels can be a loss of license and court sentences, including substantial material damages if guilt is proven.

There is also a downside to this publicity: loss of the image of an omniscient and omnipotent being whom everybody believed and trusted. Doctors also lost the magical medical powers they once radiated that left patients believing that that they would certainly receive effective help.

2.4. Period of cooperation (alliance): in the future

It can be expected that in the future, the physician–patient relationship will evolve into one of cooperation on the same project: fighting against illness as the common enemy. This change has a special importance for the antipsychotic treatment of schizophrenic patients, among whom the rate of nonadherence ranges from 11% to 80%, with an average rate of approximately 50% [Fenton et al, 1997; Lacro et al, 2002]. The problem still exists despite the use of second-generation antipsychotics. One of the most-encountered reasons among psychiatric patients for omitting medication is their mistaken convic-

tion that taking drugs means that they are still ill. The thinking process goes something like this: "I take a drug, so I am ill. If I stop taking it, I am, naturally, healthy". In the continuous work with the patient, all efforts should target changing this attitude. The patient's reasoning should be changed to: "I am taking a drug to be and remain healthy". This change of attitude is obviously desirable but not always easy to achieve. To be successful whenever possible, the physician must follow some guidelines. Interestingly, in the problem of nonadherence, many factors have been studied, but the doctor's role and responsibilities are hardly mentioned in the literature. For that reason, the discussion of them here is necessarily brief.

The doctor's duties can be divided into what a doctor must not do and what s/he should do.

Things the physician should avoid:

- being cold and distant and
- speaking unintelligibly and vaguely;
- being late for arranged meetings with the patient;
- reproaching the patient (e.g., "why haven't you done this… why haven't you…" etc.);
- belittling the patient's statements (e.g., "what you are talking about is totally irrelevant, you should forget it at once", etc.); and
- too firmly dissuading the patient from personal beliefs (for the patient, reality has a meaning different from that for the doctor; thus, the patient should be carefully and gradually brought nearer to actual reality as much as possible).

The patient is usually abruptly confronted with signs and symptoms of a disease that can overwhelm him/her with dilemmas and fears. The patient cannot share these problems in the usual social environment because others can rarely understand them. Thus, a doctor must be the person who will receive the patient kindly, with interest, making it easier for the patient to talk about problems. In conversation with the patient, the doctor's communication style must be clear and intelligible, adjusted to the patient's education and abilities to comprehend. By making an appointment at a set time, the doctor shows that he respects the patient and the patient's time. It is much better to praise what was good while also noting that work still remains but that there is time for the mutual efforts it will take to achieve them.

The patient's disturbances should be taken seriously. Even when psychiatry textbooks describe them as mild, the experience of the patient's complaints is not necessarily minor. If the doctor takes all of the complaints seriously, the patient is motivated to engage in a more open dialogue because "I see s/he understands me and my problems, so I can speak about them freely to him/her". The doctor must realize the final limits of the therapeutic possibilities. By trying at all costs to eliminate the voices that the patient hears, raising therapy to maximal doses, the physician can probably reduce the voices; however, at the same time to the excessive side-effects may substantially reduce the patient's quality of life.

Things the physician should do:

- define illness from the patient's point-of-view and define target symptoms and severity;
- be capable of recognizing the illness in all its peculiarities and details;
- recognize reality as the patient experiences it in order to choose the best possible therapy;
- provide a rationale for the use of medication (mention beneficial effects, disclose side-effects);
- constantly show empathic interest in the patient;
- know the relationships within the family and continuously be informed about them as much as needed to understand the patient's state and functioning in the family;
- understand the importance of follow-up visits for enhancing and monitoring compliance;
- assess the response and possible side-effects and manage them;
- show interest in every aspect of the patient's life;
- establish a therapeutic alliance and discuss alternative treatments; and
- know how to encourage the patient, especially during periods when the condition is worsening.

The disease is not the major concern of the doctor's work: The major concern is the patient, an individual with a set of characteristics that makes the occurrence of the disease in that particular patient a unique phenomenon. The doctor must know the patient's perception or negation of the disease and must adequately adjust approach and therapy. The purpose, effect, and side-effects of therapy must be explained sintelligibly. For example, each depressive patient must be warned that antidepressants do not have an immediate

effect but have a latency of 3 or even 6 weeks. If the patient is unaware of the delay and expects improvement after only a few days of therapy, s/he will soon be disappointed, doubts that the disease can be cured will be confirmed, s/he will stop taking the drug, and the disorder will worsen. The description of side-effects should not be too excessive, with mention of only the most essential factors or the severe side-effects.

Presenting to the patient the possible severe side-effects is important. In addition, the doctor must explain why so many side-effects are listed in the patient leaflets; the sheer quantity of these scares almost every patient at the beginning of therapy. Objectively, probably anyone, even if perfectly mentally healthy, would hesitate about taking a drug for which there are 10 or more possible side-effects, particularly when some of these side-effects sound much worse than the illness itself. Obviously, in the case of a suspicious or openly paranoid patient, these leaflets detailing the numerous side-effects can cause great fear and repulsion about a drug that appears so harmful. Thus, the doctor must select the most essential facts and dispel fears a patient might have from such detailed descriptions.

Insight into the family relationships is also important, as are the attitudes of family members regarding the patient and their expectations. The doctor should try to achieve from relatives the optimal level of expressed emotions for the patient and the course of the disease; otherwise, familial utterances could be damaging. For example, a depressive female patient may come to the hospital accompanied by her husband, who describes her in the following way: "She was a remarkable woman and housewife, but now she is only lying in bed, does not do anything, she is totally lazy". The effect of such an attitude on the course of treatment is obvious.

The doctor must always be ready to accept the patient's remarks and observations and must seriously consider them and then talk to the patient. This approach helps achieve alliance with the patient in fighting the common enemy, the disease. The patient should also be taught how to live with certain disturbances in the best possible way because some conditions cannot be completely improved. In fact, the best illness outcome is achieved in patients who have some (or even better, complete) insight into the illness itself and who manage to create a positive attitude towards therapy. Here, it is assumed that patients know that therapy is necessary and that taking medication on the correct schedule and in the correct dose is the guarantee for maintaining their good condition. Instructions that are particularly transparent and as

concise as possible must be given to elderly patients. In these persons, mistakes in taking medication occur very often; the frequency of such errors can reach as high as 75% [Salzman, 1995], causing many consequences, some of them fatal.

From the historic point-of-view, we see that the relationship between the doctor and patient has advanced from absolute obedience through compliance to cooperation. It has not, however, been excluded that insisting on obedience can sometimes be very beneficial for therapy maintenance in a patient who cannot attain adequate compliance, not to mention cooperation. Of course, this hard-line approach should be an exception; the goal should be establishing a cooperative relationship in which the patient will be the psychiatrist's partner in decision making. The best results in therapy are achieved only in patients who can take charge of their own therapy, and who, by knowing their disease and the drugs they use, can adjust therapy according to their condition. Clearly, in all cases, there is the standing counsel that they can, whenever they are unable to cope, turn to their doctor for additional advice. Thus, the doctor's role and responsibility in patient adherence to therapy is very important, and we should be prepared to take on that part of the responsibility.

References

1. Fawcett J. Compliance: definitions and key issues. J Clin Psychiatry. 1995; 56(suppl. 1) 4-8.
2. Fenton WS, Blyler CR, Heinssen RK. Determinants of medication compliance in schizophrenia: empirical and clinical findings. Schizophr Bull. 1997; 23: 637–651.
3. Johnson MJ, Williams M, Marshall ES: Adherent and nonadherent medication-taking in elderly antihyperetensive patients. Clin Nurs Res. 1999; 8: 318-335.
4. Kissling W (1991). The current unsatisfactory state of relapse prevention in schizophrenic psychoses – suggestion for improvement. Clin Neuropharmacol. 1991; 14(suppl 2): S33-S44.
5. Lacro JP, Dunn LB, Dolder CR, et al. Prevalence of and risk factors for medication nonadherence in patients with schizophrenia: a comprehensive review of recent literature. J Clin Psychiatr. 2002; 63: 892–90.
6. Lin EH, Von Korff M, Katon W et al. (1995), The role of the primary care physician in patients' adherence to antidepressant therapy. Med Care. 1995; 33(1): 67-74.
7. Menzies, R., Rocher, I. and Vissandjee, B. (1993): Factors associated with compliance in treatment of tuberculosis. Tuber. Lung Dis. 1993; 74:32-37
8. Salzman C. Medication compliance in the elderly. J Clin Psychiatry. 1995; 56(suppl 1): 18-22.