

DRUG NON-COMPLIANCE IN MANIA: THE INDIAN EXPERIENCE

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ABSTRACT

A prominent relationship has been proposed between compliance and various factors, like the patient's individual characteristics, the illness and medication being prescribed to the patient. We compared 20 manic patients who were non compliant to medication with a control group, who were matched on the demographic variable, illness variables and the treatment prescribed. We first examined the reason for non compliance from the patient's perspective, and found out the commonest reason for non compliance to be 'side effect of the medicines' (35.0%), followed by the sense of 'feeling well' (30.0%). On assessing the patient's personality traits using 16PF, we found significant elevation on factor L, signifying characteristics like pretension, jealousy, suspiciousness etc. On the DMI, the patients got significantly lower scores on the variable PRN - indicating less use of defenses like intellectualization and rationalization. Based on these findings we came to the conclusion that noncompliant patients use less of mature defenses and more of primitive defenses.

Key words - compliance, mania, personality traits, defense mechanisms.

Non-compliance is a common problem encountered by all health professionals (Blackwell, 1992). Various factors which determine the compliance of a patient have been identified. These factors can be broadly classified into the following-patient variables (i.e. demographics, personality differences, attitude, and the defenses used, etc), illness variables (i.e. diagnosis, illness content, chronic illness, etc.), and treatment variables (i.e. treatment setting, simple or complicated treatment regimen, cost of the medicines, side effects of the medicines, etc.) (Blackwell, 1989, 1992, Fawcett, 1995). So far more than 200 variables have been examined, but more than half of the studies have failed to reveal any association between compliance and most of these variables (Blackwell, 1992).

Non compliance has various serious consequences, like patients not receiving the full benefit of a treatment protocol to repeated and prolonged hospitalizations, hence the issue

merits serious consideration by practicing clinicians.

MATERIAL AND METHOD

This study was conducted at the Central Institute of Psychiatry, Ranchi. The experimental group was taken from the OPD and constituted of 20 consecutive, non compliant manic patients, who fulfilled the ICD-10 criteria (WHO, 1992) for Bipolar affective disorder, mania. Non compliance was defined as being off medication for atleast 1 month against medical advice. A control group of compliant manic patients who were matched for the demographic variables, (age of onset, duration of illness, number of illness episodes) and the treatment prescribed was also taken from the O.P.D. Only literate patients were included in the study.

The exclusion criteria was : patients with any evidence of organicity, with any psychiatric comorbidity and aged below 16 years.

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The details of the patient's demographic data, illness variables and medication were recorded. The personality was assessed using the Hindi version of the 16 Personality Factor Questionnaire (16 PF) (Kapoor, 1970 a & b; Kapoor & Tripathi, 1981 a & b) and the Defense Mechanisms Inventory (DMI) (Mrinal & Singhal, 1984) was used to study the defense mechanism used by the patients. The reason for non compliance, as reported by the patient was also recorded. The sample constituted of employed and unemployed patients coming from rural as well as urban areas. Various level of education as well as socioeconomic status were adequately represented in the sample.

RESULTS

The experimental group consisted of 18 males and 2 females. 13 patients were married and 7 patients were single. The mean age of the non compliant patients was 28.45 ± 11.09 yrs. whereas the mean age of the control group was 26.45 ± 8.34 yrs ($p=N.S.$).

The mean age of illness onset of the experimental group was 21.05 ± 5.46 yrs. with the mean duration of illness being 5.75 ± 8.09 yrs. The mean number of episodes was 3.15 ± 2.21 .

In the experimental group 10 patients were on mood stabilizers, 5 patients on mood stabilizers and antipsychotics and 5 patients only on antipsychotics.

The commonest reasons cited for discontinuation of medication were side effects of the drugs (35.0%) and a sense of 'feeling well' (30.0%). This was followed by poor financial condition (10.0%), inability to contact the doctor (10.0%), social stigma (10.0%) and miscellaneous reasons (5.0%).

On 16 PF, the non compliant patients had a significantly higher score on factor L compared to the compliant patients (6.20 ± 1.79 vs 4.35 ± 2.25) ($t=2.87$, $p<0.05$).

On DMI the non compliant patients had a significantly lower score on the variable principalization (PRN) (42.700 ± 5.312 vs 46.3000 ± 4.943).

DISCUSSION

Our patients were matched on the demographic variables, illness variables and treatment variables as closely as was possible, and then we tried to examine the overt reasons for drug non-compliance (i.e. what the patients told us) and the covert reason (i.e. what the personality test and the defence mechanism inventory revealed to us). The commonest reason cited by the patients for discontinuing medication was side effects of drugs, a fact recognized by many. It is estimated that 20% to 30% of bipolar patients discontinue lithium against medical advice because of side effects. In case of neuroleptics, the extremely distressing and frightening experience of dystonia, akathisia and akinesia have been shown to be directly associated with medication non compliance. Asymptomatic illness has been recognized as one of the factors that decreases compliance. Various workers have reported that in patients whose illness is in remission, the discontinuation of medication may reflect an attempt to deny the existence of the illness.

The non compliant patients were found to have a higher score on factor L, which is indicative of characteristics like pretension, jealousy, suspiciousness of interference, irritability, etc. Much of the behaviour of such individuals may be identified with the persistent adoption of true projection. Our findings were consistent with the views of Book (1973), that patients with paranoid trends who rely on projective mechanisms and degree of fluidity in self-object differentiation, often experience the ingestion of medicine as a risk for being poisoned, influenced or hypnotized. A similar view was expressed by Fawcett (1995), that in patients who are extremely suspicious or who show high sensitivity to physical symptoms, any association with negative schema (i.e. fear of symptoms as evidence of damage to one's body and impending danger) often creates a negative attitude towards the drug.

The non compliant patients had a lower mean score on the factor-principalization, which

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includes defenses that deal with conflicts through evoking a general principle that 'Splits-off' affect from the content and represses the former, like intellectualization and rationalization. These findings indicate that non-compliant patients use less of mature and sophisticated defenses and more of primitive defenses like projection, denial, identifications and displacement. In bipolar patients, denial has been shown to cause refusal to take lithium. In an earlier study, Gleser & Ihilevich (1969) had shown that the factor principalization is negatively correlated to the paranoia scale of the MMPI, which was similar to our findings. This further lends support to our views.

In the end we would like to emphasize that there is nothing like a stereotypical 'drug defaulter' and that every patient we see is a potential defaulter. Compliance depends on a complex interaction between the patient, his illness, the physician and the medications he prescribes. Some of the risk factors are easy to control (such as the drug regimen and side effects of drugs), others are manageable, but more resistant to change (such as the patients personality and attitudes), and some are beyond our control (such as the patients age, sex, race etc). Our sample size was very small and had an over representation of males, hence any generalization should be made with caution. Further, issues like social support, family structure, perceived stress and therapist variable were not addressed to in this study.

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