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Case Presentation
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Psychological Barriers in the Treatment of a Patient with a Generalized Anxiety Disorder - A Case Report of Pregabalin Treatment

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Background

The effectiveness of pharmacological treatment of psychiatric disorders depends not only on the action of the drug as a substance with a therapeutic effect determined by biological mechanisms but also on a range of psychological factors related to the patient and their relationship with the doctor [1,2]. The individual who takes the drug assigns multiple meanings both to the drug itself and to the fact of taking it [3]. Considering that today's patients often seek diagnosis online before visiting a doctor, and verify the recommendations received after the appointment itself, they often arrive at their doctor's doorstep having already formed a preconceived opinion about their alleged condition and the treatment required. In some cases, this can make consultation easier; in others, it may result in increased difficulties in introducing the correct drug therapy. In the latter case, the doctor's clinical experience may prove to be of paramount importance [4]. This paper describes the case of an individual suffering from generalized anxiety disorder who presented for counselling with a self-diagnosis of dissociation and a hesitant attitude towards pharmacological treatment. The first step enabling the introduction of treatment was to reformulate the patient's prior beliefs.

Case Presentation

A 38-year-old IT company employee came forward with complaints of "derealization and dissociation", which he diagnosed himself with based on descriptions available online, claiming that "there are no cures for this", also based on internet sources.

First appointment

The patient described the symptoms experienced in a way that mostly corresponded to his self-diagnosed condition, saying: "I have been in a state of permanent dissociation and derealization for 3 weeks. In these states, I feel like I'm doing everything on autopilot; my consciousness is watching what I'm doing; these states are exacerbated in stressful situations. My stress resistance has dropped to zero." Further, he added the following: "I have also read that there is no treatment for dissociation and derealization, only psychotherapy can help."

The meaning structure imposed by the patient at the onset of the appointment was based on a diagnosis formulated by the patient himself and a narrowing of the range of treatment options available. Yet, at the same time, the patient reported to a psychiatrist rather than a psychotherapist, which indicated uncertainty about his own attitude. During anamnesis, it was established that the patient had already experienced such a state of mind before. He recounted: "I had already felt like this at one point, the previous time was after a party, during which I had taken a psychoactive substance".

The patient made a connection between the two periods when he was experiencing similar feelings, saying that the psychoactive drugs he had taken many years before had permanently damaged his brain, with his current state being a manifestation of biological brain damage. Sharing this concern expanded the scope of the conversation to include a new area: Anxiety. This made it possible to go beyond the meaning of "dissociation and derealization" - for which "there are no cures" - as proposed at the beginning. It soon turned out that the patient was facing an increased workload and experienced more pressure at work (which he caused himself) and believed his workplace intellectual performance to be declining. His interpretation was as follows: "I am not so efficient at work because I had damaged my brain at that time; this damage has permanent consequences".

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Subsequent statements by the patient directly pointed to anxiety symptoms

"My thoughts are that I'm very scared it's going to get worse; I'm going to run out of strength to fight it. I feel like I'm losing my identity in a way. I have this question about who I am, what I want and what is important lingering over my head. Profoundly philosophical. I am afraid this condition will get worse. I am afraid that something might happen to me, a serious illness. If I wake up in this state at night, all I want to do is survive; sometimes panic sets in."

He also reported experiencing a "constant feeling of anxiety" and claimed: "I have always been thinking of what might go wrong; my head couldn't stop; I would go from a minor thing to tragic consequences." The patient had a multifaceted neurological diagnosis. No features of CNS neurological problems were found.

This statement by the patient also indicated another aspect of the treatment that proved crucial. One important value for the patient was his identity - the question "Who am I?". Indeed, this question made the context of treatment more meaningful still. It made it clear that the patient would not accept treatment that would lead to a subjectively discernible violation of his sense of identity. The patient needed to be in control of himself and that which concerned him. After all, he reported to the doctor with a ready-made self-diagnosis and views on the possibility of receiving help. In the subsequent part of the conversation, he stressed the importance of his sense of self, of who he was.

After reformulating the diagnosis from "dissociation and derealization" to "anxiety disorder", to which the patient agreed, he was presented with a description of generalized anxiety disorder. The patient fully identified with this description. Treatment with pregabalin was then suggested, which included a reference to the presentation of drug-related information and the summary of product characteristics. The remainder of the visit was spent discussing the patient's fears, anxieties and beliefs about the possible use of the drug. While the patient ultimately agreed to take pregabalin, he did indicate that he had an appointment with another psychiatrist to get a "second opinion".

Further treatment stages

The second opinion he sought confirmed the recommendation to take pregabalin. At the follow-up appointment, the patient reported that "This drug has helped a little, I don't have as many panic attacks". He was taking 75 mg of pregabalin at the time; however, he did not consent to an increase in the dosage of the drug. He feared that taking higher doses would make him lose his identity. Subsequent appointments with the patient can be described as a "negotiation" between the desire to take higher doses of pregabalin, linked to perceived improvements in mood and function, and fears of losing control. Although the patient had carefully read the information about the drug, including the dose range starting from 150 mg, and did not dispute this information, he expressed strong concerns about increasing the drug dosage (and simultaneously a desire to do so). These concerns applied even to the threshold dose indicated in the leaflet. The patient was concerned about losing control over himself and his well-being, as well as suffering a loss of identity, and feeling a sense of dependence on a drug - a factor beyond his control.

After increasing the dose of pregabalin to 150 mg, the patient experienced a marked improvement, including in terms of mood and function throughout the day. As a result, he grew even more hesitant about the drug he was taking. The drug's effect proved to be very helpful; the irritating and function-limiting symptoms he had been suffering from for years began to disappear. On the other hand, this confronted the patient with the feeling that his well-being was not entirely up to him and was not fully under his control, raising his fear and, ironically, creating some anxiety. Nonetheless, so great were the benefits of taking pregabalin that the patient opted for another dose increase to 225 mg. The features of generalized anxiety have subsided, and the patient's functioning in many spheres has significantly expanded in capacity. The patient reframed his mindset, recognizing that "I'm myself the way I am now". He was satisfied with the new opportunities to meet other people (which had previously been significantly limited), to travel and go on trips, and the significant improvement in his workplace status and image.

Conclusions

- An important feature of generalized anxiety disorder is a specific form of anxiety - thinking of negative scenarios of future events, anticipatory anxiety and having anxious thoughts about the future. Individuals suffering from this disorder often craft elaborate scenarios full of negative expectations based only on a piece of trivial information [5].

- Their anxiety can take many forms, some of which do not directly indicate that they are experiencing it. Patient complaints can include a range of somatic and psychological symptoms, as well as a variety of behaviors. To formulate a diagnosis, it is necessary to carry out a more thorough history taking and discuss with the patient the content of the experiences underlying the reported symptoms.

- Individuals suffering from anxiety may express fear of treatment and various aspects of it, including those of a highly improbable nature. This fear should be thoroughly discussed to ensure the patient's cooperation in treatment. If the patient's hesitant attitude towards treatment is dominated by fears rather than hope for improvement, their cooperation in the treatment will be incomplete.

- In treating mental disorders, the dimension of subjective and psychological aspects of treatment is often crucial [1-3]. Such phenomena often determine cooperation in treatment. They are based on the subjective feeling of the drug's effect (the perception of "what the drug does to me") and the interpretation of this effect [6]. These interpretations are individual and result from the patient's life history and numerous psychological conditions like confidence levels, values held or culturally based perceptions about the effects of substances prescribed by psychiatrists. The sense of identity, of being oneself and of "not compromising one's personality" during treatment is vital to the success of treatment in some patients with mental disorders.

- Personalized selection of pharmacological treatment appropriate to the diagnosis and the given patient plays an important role here [7,8].

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