Maintaining the Therapeutic Alliance in Modern Pharmacotherapy Practice

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Question 1

- Which of the following statements about the "working alliance" is true?
- A-It is involved in all forms of therapy
- B-Both therapist and patient collaborate
- C- Bonds between therapist and patient include mutual trust and confidence
- D-When working with children, always involves a dual alliance with parents
- E- All of the above

Question 2

- What traits of therapist fosters the development of the therapeutic alliance? Choose one.
- A-Kowledge of pharmacotherapy
- B-Early take-charge attitude
- C-Emotional reactivity
- D-Emoted understanding of patient's problems
- E-Rational estimate of possibility of success

Question 3

- A negative factor influencing adjustment of a youth to taking medication includes?
- A-Teachers who stigmatize youth at school
- B-Prescriber is seen as agent of the parent
- C-"Meaning of medication is need to fix damaged goods"
- D-Success is attributed to pill not child
- E-All of the above

Question 4

Which of the following tactics can improve adherence to medication?

A-Only get “buy in” for medication usage from parents

B-Discuss the appropriateness of medication intervention for older teen

C-Explain that medication will do all the work in changing symptoms

D-Only get a “buy in” for medication usage from child

E-None of the above

Question 5

- Which of the following are important for continuing education of the prescriber?
- A-Know and read the websites frequently used by parents
- B-Continue to learn about psychopathology
- C-Continue to learn about pharmacology
- D-Foster communication with teachers
- E-All of the above

Teaching Points

- An understanding of the therapeutic alliance is crucial to improve clinical outcomes
- A prescriber should always retain therapist skills
- Concept of a partnership between parents, youth, teachers and prescriber is the touchstone of improving the therapeutic alliance

Goals of this presentation

- Following this module, participants will be able to discuss the following questions:
  - How does the therapeutic alliance differ in work with children and teens, compared to work with adults ?
  - How can psychological factors act as powerful enhancers, distorters or neutralizers of medication effects?
  - How do we understand these factors in order to promote better treatment outcomes?
  - What are the psychological implications of administrating medications?

Introduction and Overview

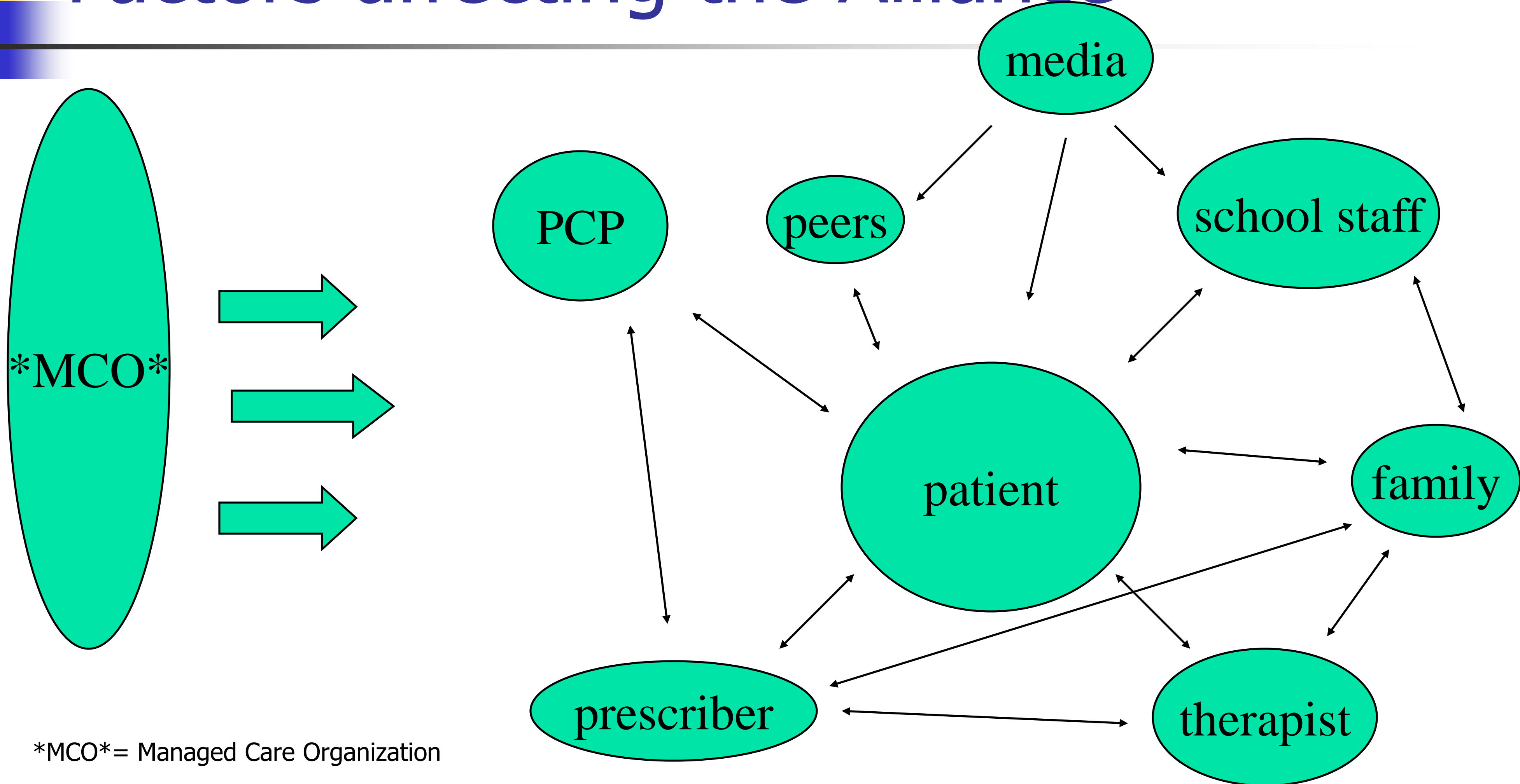
- The role of the therapeutic alliance in child & adolescent psychiatry
- The psychological implications of administering medications
- Some of the specific developmental issues to be acknowledged when working with children and adolescents of varying ages
- The role of the dual alliance (with both patients and parents) for practitioners of psychopharmacology in both specialty and primary care settings
- Recommendations for clinical practice and further research in this area.

Introduction and Overview

- *"…beneath a veneer of postmodern disconnect, the therapeutic interaction is at its core a relationship between two people, doctor and patient, in a room. Continued attention to, and discussion of, the nuances of their interaction enhance the possibilities of a successful, and indeed a personally meaningful outcome for both parties involved." pg.47*

Metzl JA (2000) Forming an effective theraputic alliance. In: Tasman A, Riba MB, Silk KR, eds. The doctor-patient relationship in pharmacotherapy: Improving treatment effectiveness. NY: Guilford;25-47.

Factors affecting the Alliance

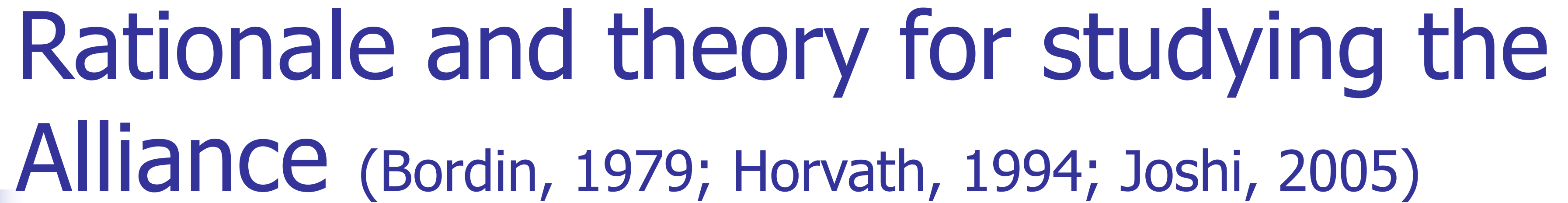


Rationale and theory for studying the Alliance

- We *must* be able to retain our abilities as therapists
- We must approach all aspects of our work with a psychological perspective (Carli, 1999)
- The doctor-patient relationship as a “drug-delivery system” (Beitman, et al, 2003)
  - Better therapeutic alliances predict a more favorable medication response (Krupnick, et al, 1996)
  - Outcome is poor if the relationship solely focuses on monitoring symptoms and side effects (Murphy, et al, 1995)

Definition of Working Alliance

- Common to all forms of psychotherapeutic intervention
  - *Mutual collaboration against* the common foe of the patient's presenting problem(s)
  - Integration of both the *relational* and *technical* aspects of treatment



Rationale and theory for studying the Alliance (Bordin, 1979; Horvath, 1994; Joshi, 2005)

- The collaboration between therapist and client involves three essential components: *tasks, goals,* and *bonds*.
  - *Tasks* are the in-therapy behaviors and cognitions that form the basis of the therapeutic process
  - If the relationship is strong, *both* therapist and client perceive the tasks in therapy as relevant and potentially effective, and each party accepts the responsibility to take part in these tasks
  - A strong working alliance involves both therapist and patient mutually endorsing and valuing the *goals* (outcomes) that are the targets of an intervention
  - The term *bonds* acknowledges patient-therapist attachment status, and includes mutual trust, acceptance, and confidence

Rationale and theory for importance of this approach

- Therapeutic Alliance
  - The collaborative bond between therapist and patient
    - And parent!
    - Thus, in work with children, there is always at least a DUAL ALLIANCE
- The offer of treatment is a non-neutral act
  - It represents a sort of conditional promise or hope for the future
- "Prescription" as a misnomer
  - Prescriptions are typically written within a relational context

Rationale and theory for importance of this approach

- Therapeutic Alliance Measures (Adults)
  - Penn Helping Alliance Questionnaire (Luborsky,1996)
  - Working Alliance Inventory (Horvath & Greenberg, 1989)
    - Goal
    - Task
    - Patient-therapist bond
  - California Psychotherapy Alliance Rating Scale (CALPAS; Marmar, et al. 1989)
  - California Pharmacotherapy Alliance Rating Scale (CALPAS-P; CALPAS-T; Weiss, et al. 1997)
- The therapeutic alliance: Soon to be a measurable psychotherapy skill in training programs (Kay, 2001)
- Recognized across paradigms as a cornerstone of effective treatment

Empiric Support

- Therapeutic Alliance in psychotherapies
  - Much empiric support for its relevance and relationship to positive outcomes (Children, Teens and Adults)
- Therapeutic Alliance in pharmacotherapies
  - Empiric support now growing
- Therapeutic Alliance in pharmacotherapies with children / teens
  - WANTED: Empiric support!

Empiric Support

- In child psychology: Most research focuses on interpersonal process
  - Therapeutic engagement with teens and children
  - Dual alliance with parents and other caregivers
  - Moderators and mediators
    - Client, patient, therapist characteristics
    - In-therapy variables
    - Temperamental (good enough) “fit” among dyad

Empiric Support

- Literature in psychotherapy over past 30 years
  - Quality of Alliance is at the base of all effective therapies
  - Independently predicts outcome with modest success (Effect Size=0.21-0.30) (Horvath, 1994)

Empiric Support

- Specific variables:
  - interpersonal skills (expressed responsiveness and the ability to generate a sense of hope)
  - open, clear communication style
  - emoted understanding of patient and specific problems
  - minimal “negative therapist behaviors”
    - a “take charge attitude” in the early phases
    - a therapist whom the client experiences as “cold”
    - premature insight or interpretation
    - therapist irritability

Empiric Support

- By when is the alliance usually established?
  - Adults vs. Children/Teens
    - Adults, by session 3
    - Children/teens, established often by later than session 3, but begins immediately (Joshi, 2006)
  - Differences in pharmacotherapy vs. psychotherapy vs. integrated yet to be investigated

Empiric Support

- Weiss, et al (1997)
  - Prospectively examined the alliance in pharmacotherapy of adult depression;
    - n=31; 2yr study
  - Alliance was highly correlated with outcome
  - CALPAS-P; CALPAS-T (California Pharmacotherapy Alliance Scales, Patient and Therapist versions)
  - *Pharmacotherapist perception of alliance* was a more reliable predictor of outcome compared to patient perception

Psychologic analgesics (Havens, 2000; Joshi, 2006)

- 1) Protect self-esteem: It is safe to assume that the *patient's* self-esteem has been potentially affected by having to come to your office, and that the *parent* is feeling sufficiently bad for having caused the illness, through bad parenting, poor gene contribution, or both. Be mindful of how you help the patient and parent "hold it together" in your presence.
- 2) Emote a measure of understanding and acceptance: When this is successful, you've not only grasped the patient's problem intellectually, but you've *really conveyed* an understanding of the patient and family's predicament from *their point of view*.

Psychologic analgesics (Havens, 2000)

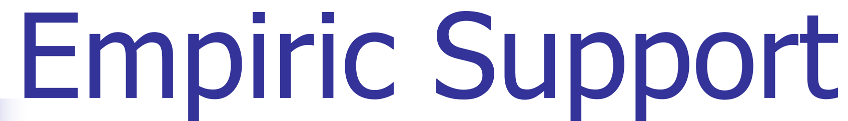
3) Provide a sense of future: Many families come to us having experienced much frustration and failure at finding usable solutions, and have lost hope. Have discussions about what they'd like to achieve in treatment, and acknowledge their hopelessness while still offering reminders of the potential for change, "It seems hopeless to you *now*."

Empiric Support

- In pediatrics: Always remember the dual alliance
- Parents as Partners Model(DeChillo, et al (1994); Alexander and Dore, 1999)
  - Examined negative beliefs often held by clinicians
    - Psychiatrists are less likely than other therapists to embrace parents as partners
  - “Partnership practice”: normalizes the reality that families have variable responses to stressors in their lives.

Empiric Support

- DeChillo, et al (1994)
  - Pro-active vs. Less pro-active sense
    - Often a struggle for trainees with a more psychodynamic stance/strictly adult training
  - Importance of commitment to vulnerable "difficult" families
  - Accordingly, the type and severity of family problems should not pose insurmountable barriers to effective partnerships, as long as the clinician is truly committed to the process, and possess skills to engage these families



Empiric Support

- Hawley & Weisz (2005): n=65 youths (and their parents/caregivers)
  - parent (but not youth) alliance was significantly related to more frequent family participation, less frequent cancellations and no-shows, and greater therapist concurrence with the decision to end treatment
  - youth (but not parent) alliance was significantly related to *both* youth and parent reports of symptom improvement.
  - Thus, both alliance relationships, while crucial, may differ in important ways

Empiric Support

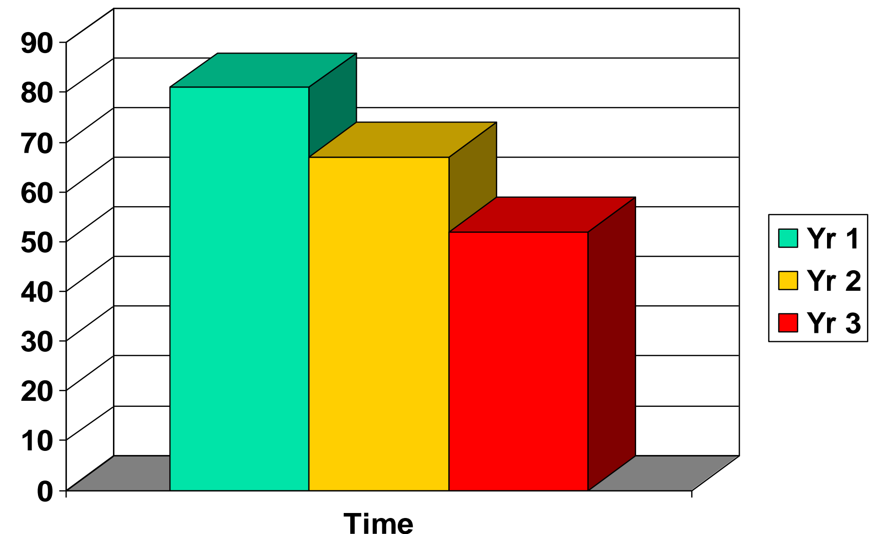
- Kazdin, et al (1997):
  - A poor alliance was one of the factors predictive of treatment dropout within families of children with externalizing symptoms on the oppositional-defiant-antisocial continuum

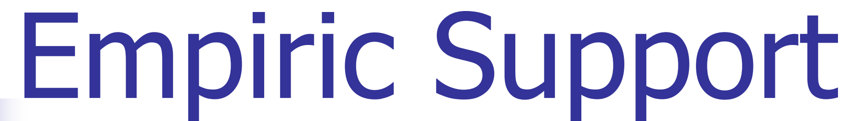
Empiric Support

- Nevas, et al (2001)
  - Parents, in general, experience primarily positive attitudes and feelings about their child’s therapist, with tendencies to feel hopeful, understood, and grateful

Empiric Support

- Moderators and mediators of long-term adherence in children and teenagers with ADHD; Thiruchelvam, et al, ***JAACAP***, 40 (8); 2001
  - **N=71; ages 6-12 yrs;** prospective PBO-controlled trial, 12-month tx, then 2 year follow-up
  - **Measures:** Tx Monitoring Questionnaire **(TMQ)- for parents, teachers**
    - Child Satisfaction Survey **(CSC)- for children**
- Adherence rates : 81% yr 1, 67% yr 2, and *52% yr 3*



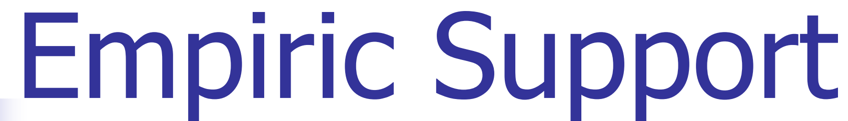


Empiric Support

- Thiruchelvam, et al ***JAACAP***, 40 (8);2001,922-28 continued
  - Moderators of adherence: Positive predictors included
    - More teacher-rated severity of ADHD
    - Absence of ODD in school
    - Younger age at baseline
  - Mediators of adherence
    - A positive response to treatment at 12 months was not clearly associated with stimulant adherence
    - Therapeutic alliance was not formally measured, but contacts and support with research staff decreased substantially after yr. 1

Empiric Support

- NIMH Treatment of Depression Collaborative Research Program (TDCRP):
  - **Krupnick, et al (1996): The role of the therapeutic alliance in psychotherapy and pharmacotherapy outcomes**, ***Jnl Clin Cnslt Psychology***, 64(3),532-39
  - Adult study; N=225; prospective trial, multiple therapies
    - IPT, CBT, IMI+clin mgmnt, PBO+clin mgmnt



Empiric Support

- NIMH-TDCRP study, cont'd:
  - Clinical raters scored videotapes of early, middle, late therapy sessions
  - Measures: Hamilton Rating Scale for Depression (HAM-D); Beck Depression Inventory (BDI)
    - *Vanderbilt Therapeutic Alliance Scale* (VTAS), Hartley & Strupp (1983), adapted version
      - 44-item measure ; 3 subscales
        - Therapist, Patient, Therapist-patient interaction

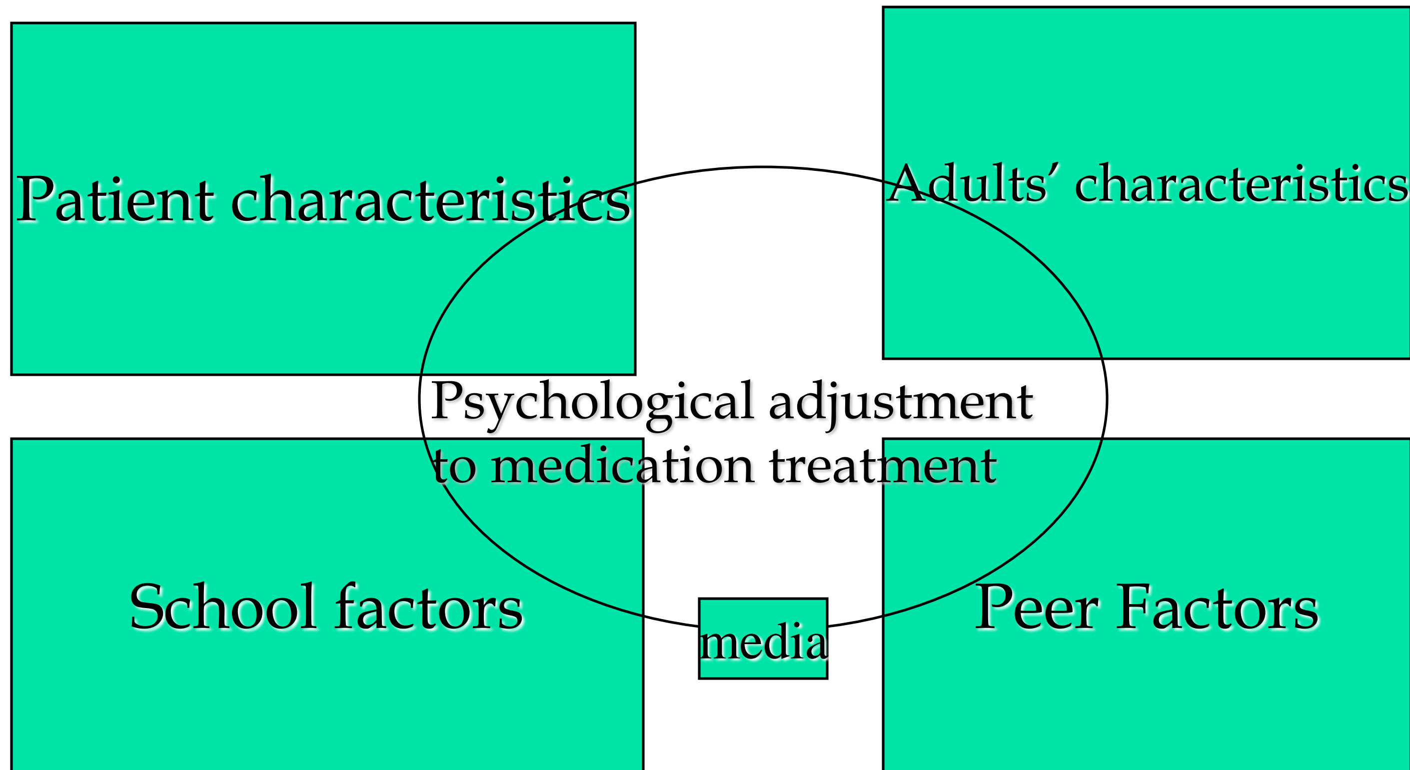
Empiric Support

- NIMH-TDCRP study, cont'd:
  - Results: Therapeutic alliance had significant positive effects on clinical outcomes for both psychotherapies and pharmacotherapies
    - Med group results (IMI+cm, PBO+cm) : <u>Alliance alone may have strongly influenced the placebo response.</u>

- ***“Thus, the role that the therapeutic alliance plays in affecting outcome extends…beyond psychotherapy itself, <u>with implications for the way in which pharmacotherapy is conceptualized and practiced”</u>***

-Krupnick, et al.(1996)

Factors affecting adjustment to medication treatment



Factors affecting adjustment to medication treatment

- Patient characteristics
  - -Internal working model of receiving help and support
  - -Attachment status
  - -Age of child / teen
  - -Past outcomes
  - -Relationships with MDs, teachers, counselors
  - -Transference influences ability for alliance formation

Factors affecting adjustment to medication treatment

- Adults’ characteristics
  - Important because of context in children’s lives
    - Young children especially dependent on family/school attitudes toward medication
    - Adherence promoted when adults ascribe successes to child (rather than to medication)

Factors affecting adjustment to medication treatment

- School and peer factors
  - Teachers and nonverbal cues
    - Psychologically minded teachers will be sure to make medication reminders as subtle as possible
      - ("Timmy, did you take your meds today?" : NOT HELPFUL)
      - (Teacher walks by Timmy and gives a signal (eg. squeeze on shoulder or a folded note) which reminds him of need to go to the school nurse for medication : MOST HELPFUL
  - Connection to a peer or famous person with a similar problem may help de-stigmatize the need for medication
    - ADD.org, NAMI.org, CHADD.org all have examples
    - http://www.nami.org/Content/Microsites88/NAMI_Olmsted_County/Home84/Links6/Famous_People/famous_people_with_mental_illness.doc

Factors affecting adjustment to medication treatment

- School and peer factors
  - Teens’ feeling “different”
    - Damaged goods dynamic
    - Prescriber
      - Needs to be experienced as ally of the teen, much more than an agent of their parents

- Media factors
    - Internet, music videos, television, print media

*"Psychopharmacotherapy"

- Defined as the combined use of psychoactive medication and psychotherapy (Pruett & Martin, 2003; Schowalter, 1989)
- Components (discussed over the next 10 slides)
  - The decision to offer medication
  - How and when to present the idea
  - The act of writing and giving the prescription

*Psychopharmacotherapy

- Components, continued
  - The meaning of the medication itself, and on the self
  - Transferring medication therapists and institutional transference
  - The context and setting of the prescription

*The decision to offer medication

- Parents and patients may wonder “why now?” “Am I such a failure as a patient?,”
  - Especially if the idea is presented in a non-sensitive manner

*How and when to present the idea

- Best discussed at the outset, during the intake process
  - Allows for open discussion re: potential benefits/ side effects
  - Eases the task of “bringing up meds” as an intervention later in the course of therapy
- Special issues in combined (“split”) treatment

*The act of writing and giving the prescription

- Best saved until the very end of a session
  - After adequate time has been devoted to questions from both patient and parent
- Tailor explanation
  - Developmental *age of child*
  - Developmental *stage of parent*
- Most middle- and older teens:
  - comments and prescription should be directed primarily to them

*The meaning of the medication itself, and on the self

- Teens' developmental tasks
  - May feel "changed" as a person
  - May carry on relationship with the pill itself
    - May have ambivalence in the context of improvement, especially if they feel that teachers and parents "only like me when I take my [name of medication], not for who I really am"

- "Actual" role for medication?
  - ***"All too often it is unclear whether a medication heals directly or mainly removes obstacles to self-healing"***

Schowalter, 1989; *p.683*

*The meaning of the medication itself, and on the self

- BRAND (aka *"What's in a name*?")
  - Prescriber as billboard: Drug companies spend $13,000 in direct marketing of "brand" to physicians, in the hope that they will use / display all pens, cups, notepads, and convention bags/briefcases regularly.
  - Patients may make personal connections with the name of a medicine
    - "Abilify" and "vilified"
    - "Abilify" and "ability"
    - "Geodon" and "Geodude" (Pokemon character #74)
    - "Strattera" and "stratosphere" or "strategy"

*The meaning of the medication itself, and on the self

- Fears of change in baseline personality, onset of a “zombie effect”, or a loss of ***joie de vivre***
  - Important to discuss these as potential, (but unacceptable) side effect at outset
  - Others worry that self perceptions will be altered

“I love my symptoms, Doc, they make me myself!”

(Pruett & Martin, 2003; p.418)

Beware of backhanded compliments; Use session to educate adults in child’s life about this

-parents and teachers should ascribe academic/personal gains to patient efforts, and not to medication (avoid statements such as “Great job, Billy! The new medication is really helping!”)

*Transferring medication therapists and institutional transference

- Feelings of loss and abandonment may be just as important toward pharmacologist as toward therapist **(Mischoulon, et al.** *Academic Psychiatry*, **24(3); 2000)**
- After transfer notification, departing residents reported that
  - 20% of their patients worsened
  - 32% required medication changes
  - 10% decided to stop taking their medication
- Receiving residents reported that
  - 10% worsened
  - 7% required changes
  - > 10% decided to stop medication altogether
- Transfer considered to be “major disruption” by 30% of patients
- Institutional transference

Children's concepts about medication (Adapted Pruet and Martin 2003)

Physical properties of the medication itself:

•**Name of the medicine: May help to enhance or decrease adherence, depending on association**

•**Form: liquid, tablet, capsule or injectable form may each carry specific and different meanings**

•**Size: the bigger the pill or mg size, the bigger the problem (and vice versa)**

•**Labeling & printing: personalized associations tend to be made with imprinted numbers or letters**

Children’s concept about medications (continued)

The need to take medicine:

only kids who are “sick” or “bad” have to take medicine

Timing of the dose:

Frequency: greater frequency may be seen as more trouble, or perhaps, more help

AM or PM: AM is for school, and may be neglected (with or without MD agreement) on weekends; PM is for sleeping and/or dreaming troubles

During school: concern about stigma

Who administers: self-administration is good, mature; teacher/parent administrator is the doctor’s agent

* Factors Affecting Adherence

- Caregivers' Attitudes and Roles
- Medication Side Effects
- Treatment Accessibility, Satisfaction, and Acceptability
- Therapeutic Relationship (Brown & Sammons, 2002a)

Therapeutic Relationship

- In adult studies, adherence to medication depends on :
  - The working relationship with the prescriber
  - The transference and countertransference relationships with the prescriber
  - The interventions being used
  - The "relationship" that the patient carries on with the pills themselves (Ellison, 2000)

Therapeutic Relationship (Review)

- Improved alliance and adherence leads to better outcomes (Brown and Sammons, 2002a)
  - Elementary School
    - Buy-in from both child and parent
    - Educate them together
  - Middle-, High School
    - Educate together, but consider handing prescription directly to teen
    - Older teens need to feel that the intervention is actually warranted

Stanford Specialty Clinic experiences

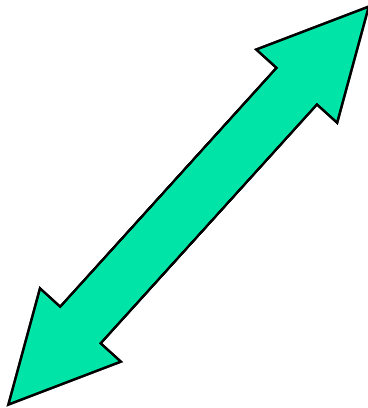
- Alliance
  - *Process* as important as *content*
- Regular clinic meetings allow for integrated treatment involving psychologists and psychiatrists, trainees and attendings
- Specialty clinics strive to be a resource for our parents and families (and vice versa)
  - Find out what they're reading (and where they're surfing!)

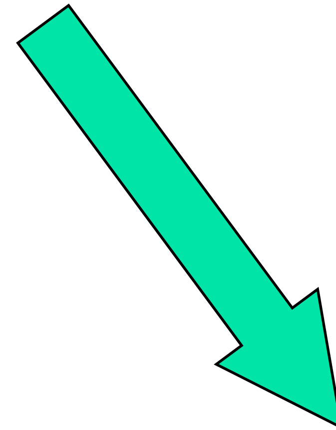
Future Directions

- More studies are needed examining the specific factors which foster the therapeutic alliance, and which lead to improved outcomes in pediatric pharmacotherapy

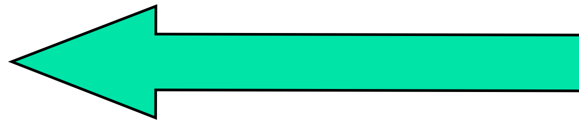
Targets of Treatment

Treatment Alliance





Better Outcomes



Enhanced Adherence

Future Directions

- Creation of a new instrument
  - to best assess the role of the therapeutic alliance in pediatric pharmacotherapy
    - two existing , valid questionnaires are being studied as models
      - California Pharmacotherapy Alliance Scale CALPAS; Weiss, et al. (1997)
      - Helping Alliance questionnaire for child psychiatry HAq-CP, Kabuth ,et al. (2003)

The Therapeutic Alliance in Pediatric Pharmacotherapy Scale (TAPPs)

Examples of PARENT items, reported on a Likert scale, 0 (not at all), 1-(slightly agree), 2-(moderately agree, 3-(strongly agree):

- The doctor and I agree on the best way to help my child
- I believe the doctor is trying to help my child get better
- I understand why my child is taking this medication
- It is *not* easy to trust my child's doctor
- I consider the doctor to be an ally of mine
- I feel that the doctor really listens to me
- I think the medicine my child is taking helps him
- I felt that the doctor "pushed" us to start medication for my child

The Therapeutic Alliance in Pediatric Pharmacotherapy Scale (TAPPs)

Examples of CHILD/TEEN items, reported on a Likert scale, 0 (not at all), 1-(slightly agree), 2-(moderately agree, 3-(strongly agree):

- I understand why medication has been recommended for me
- My doctor and I agree on the best way to help me
- It is easy to talk with my doctor
- My doctor talked about the medication in a way I could understand
- I believe the doctor is trying to help me get better
- I understand why I am taking this medication
- It is ***not*** easy to trust my doctor
- I consider the doctor to be on my side
- I feel that the doctor really listens to me
- I think the medicine is helping me

The Therapeutic Alliance in Pediatric Pharmacotherapy Scale (TAPPs)

Examples of TEACHER items, using a Likert scale 0 (not at all), 1-(slightly agree), 2-(moderately agree, 3-(strongly agree):

- I understand why medication has been recommended for this child
- My observations were a valued part of the assessment process to see if this child needed medication
- I feel free to contact this child's doctor to discuss my concerns
- The doctor should have had more contact with the school

The Therapeutic Alliance in Pediatric Pharmacotherapy Scale (TAPPs)

Examples of PRESCRIBER items, reported on a Likert scale, 0 (not at all), 1-(slightly agree), 2-(moderately agree, 3-(strongly agree):

- The child believes you are trying to help her/him get better
- The child understands why s/he is taking this medication
- The child feels that it is *not* easy to trust you
- Both parent and child consider you to be an ally of theirs
- The child feels that you really listen to her/him
- The child thinks the medicine is helping her/him

***Goals for the new combined instrument*:**

- Coherent, with a simple and useful factor structure
- Easy to use and interpret
- Will help to create evidence-based guidelines for pharmacotherapy encounters with children, teens, parents, and teachers
- Will help to create evidence-based guidelines for training directors in psychiatry to teach the practice of integrated child mental health care

Conclusions

"Too often a prescription signals the end of an interview rather than the start of an alliance"

Blackwell, 1973, *p.252*

Conclusions

- *The case formulation should be the prerequisite* to the prescription, and not vice versa
- *Emote a sense of empathy* in all of your communication with patients.
- *Involve the patient* in the decision-making process, especially in the case of teenagers
- Assess the *understanding of the disorder*, and the *meaning of medication* for the patient and family

Conclusions

- *Nurture all professional relationships* necessary to sustain the child's health (parents, other therapists, teachers, PCPs)
- *Read voraciously* about your patients' illnesses, and know the medicines backwards and forwards (side effects [and not just the major ones], drug interactions). *Do not become complacent* about your knowledge base in a specific area.
- *Visit consumer websites* often. Help get your families connected to support groups. Know what the good lay references are, and read them.

Conclusions

- In integrated treatment, when you bring up the subject of medication, *pause and listen* to the patient's and parent's associations to the word, "medication"
- *Avoid overselling* any particular drug, and monitor yourself for undue persuasion (are you trying to convince *yourself* that this is the best treatment?)

Conclusions

- *Respect* the patient and family’s right to *informed consent* and need to know about common side effects, without burdening them with TMI (too much information)
- *Provide a limited number of choices* of medications whenever possible, so that past associations to a particular product do not derail treatment
- Remain mindful that any *change*, including improvement, *may be threatening* to the patient and family

Conclusions

- Practice the *3 C's of good pharmacotherapy*
  - Collaboration (with therapists, families, other providers)
  - Conscientiousness (of the evidence-base, the standard of practice, the specific sociocultural needs of the patient and family)
  - Communication (return phone calls and e-mails promptly, be available between sessions for quick questions, document as if your reputation depended on it
    - It Does!

Conclusions

- ***Remember that all of our actions have potential meaning to the patient, from the pens we write with, to the language used to explain about mental illness, to the way we offer realistic hope for the future***

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Resources

- Kaye DL, et al: Child and Adolescent Mental Health; 2003; Philadelphia: Lippincott

excellent guide for both medical and non-medical providers, about the cost and size of the Harriet Lane Handbook

- Wilens, Timothy: Straight Talk about Psychiatric Medications for Kids, revised ed, Guilford 2004

well-written and recently revised; among the best medication resources for parents, teachers, nurses, and therapists

- Steiner, Hans (ed.): Handbook of Mental Health Interventions in Children and Adolescents: An Integrated Developmental Approach, 2004; SF, Jossey-Bass

Highly regarded evidence-based text for working with children, families, & systems

Tasman A, Riba M, & Silk, K: The Doctor-Patient Relationship in Pharmacotherapy; NYC: Guilford Press, 2000

Standard on the subject of relational aspects of pharmacotherapy with adults

Question 1

Which of the following statements about the “working alliance” is true?

- A-It is involved in all forms of therapy
- B-Both therapist and patient collaborate
- C- Bonds between therapist and patient include mutual trust and confidence
- D-When working with children, always involves a dual alliance with parents
- E- All of the above

Question 2

What traits of therapist fosters the development of the therapeutic alliance? Choose one.

- A-Knowledge of pharmacotherapy
- B-Early take-charge attitude
- C-Emotional reactivity
- D-Emoted understanding of patient’s problems
- E-Rational estimate of possibility of success

A negative factor influencing adjustment of a youth to taking medication includes?

- A-Teachers who stigmatize youth at school
- B-Prescriber is seen as agent of the parent by child
- C-Meaning of medication as need to fix “damaged goods”
- D-Success is attributed to pill not child
- E-All of the above

Question 4

Which of the following tactics can improve adherence to medication?

A-Only get “buy in” for medication usage from parents

B-Discuss the appropriateness of medication intervention for older teen

C-Explain that medication will do all the work in changing symptoms

D-Only get a “buy in” for medication usage from child

E-None of the above

Question 5

- Which of the following are important for continuing education of the prescriber?
- A-Know and read the websites frequently used by parents
- B-Continue to learn about psychopathology
- C-Continue to learn about pharmacology
- D-Foster communication with teachers
- E-All of the above

Answers

- 1-e
- 2-d
- 3-e
- 4-b
- 5-e