



The Therapeutic Alliance and Adherence in the Pharmacotherapy of Psychiatric Disorders

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Note to Lecturer

This slide set focuses on depression in particular as one psychiatric disorder in which the importance of the therapeutic alliance is well-established, but the points made about depression can be generalized to the treatment of many other psychiatric disorders.

Pre-Lecture Exam

Question 1

- 1. Depression's disabling features include which of the following?**
 - A. Functional impairment
 - B. Recurrence of episodes
 - C. Increased mortality from suicide and some medical disorders
 - D. Burden on family caregivers
 - E. All of the above

Question 2

2. Adherence is which of the following?

- A. “The degree to which a patient follows a treatment plan”
- B. Identical to “compliance” in conception and use
- C. High in patients taking antidepressant medications
- D. Higher in patients with more severe medication side effects
- E. Higher in patients asked to take a medication on a tid or qid schedule.

Question 3

- 3. Impediments to adherence include which of the following?**
- A. Excessive, immobilizing distress
 - B. Difficult treatment regimens (due to cost, pill characteristics, or dosing schedule)
 - C. Barriers accessing treatment or reaching care providers
 - D. Problems in the therapeutic alliance with the prescribing clinician
 - E. Any of the above

Question 4

- 4. Which of the following is not typically included in a pharmacotherapy visit?**
- A. Detailed exploration of early psychosexual traumatic experiences
 - B. Scheduling of follow up visit
 - C. Psychoeducation regarding a diagnosis or treatment
 - D. Eliciting reports of side effects and assessing their severity
 - E. Examining current mental status

Question 5

- 5. The pharmacotherapeutic alliance can be strengthened by all but which of the following?**
- A. Identification of patient's "request" or concerns
 - B. Attention to side effects
 - C. Psychoeducational counseling
 - D. Attention to the cost and convenience of a treatment regimen
 - E. All of the above

Major Teaching Points

- Adherence is an important element of treatment success.
- Multiple factors including the therapeutic alliance affect adherence.
- The therapeutic alliance can be improved by attention to the clinician/patient relationship and to relationships among collaborating clinicians, the treatment environment, and provision of appropriate psychoeducational information.
- Psychiatrists should be aware of evolving trends in health care that threaten to undermine the quality of the therapeutic alliance.

Brief Outline

- Definition and discussion of “adherence” in pharmacotherapy and importance of adherence in the “case example” of depression
- Definition of “therapeutic alliance”
 - Evolution of the psychiatric “med backup” role
 - Elements of the “med visit”
 - Pitfalls in the pharmacotherapy alliance
- Relevant evidence base for the concepts in this presentation
- Suggestions to clinicians for improving adherence/alliance

Major Depression: A Public Health Burden

- 12-month prevalence in US 5.3 - 8.9%¹
- Lifetime prevalence in US 17.1%²
- Lifetime relapse rate 50–80%³
- Chronic course 10-20%³

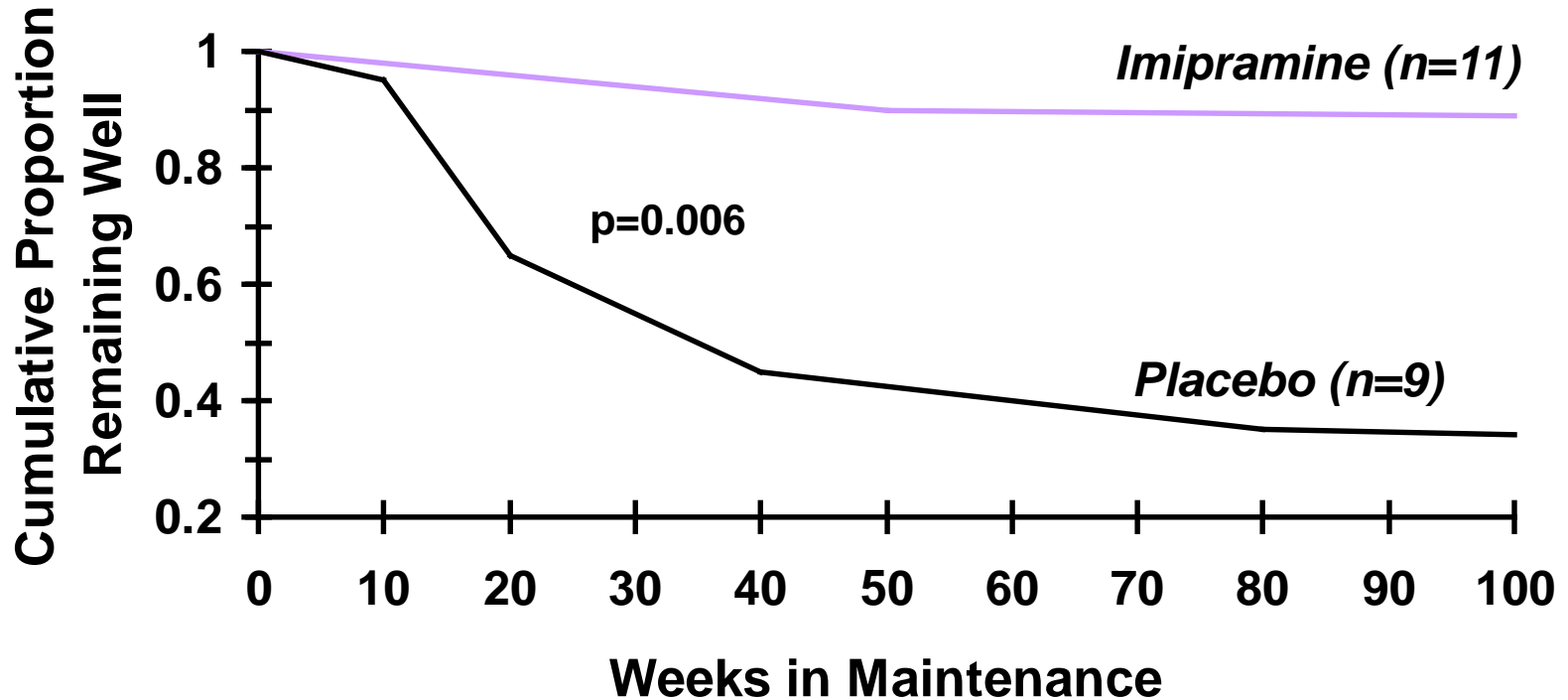
1. Satcher D, 1999: Mental Health: A Report of the Surgeon General;

2. Blazer et al. 1994; 3. Katon et al 2001

Why Is Depression Disabling?

- Suffering
- Functional impairment
- Lengthy duration of episodes
- High rate of recurrence
- Increased mortality (medical and suicide)
- Cost to family, caregivers, society

Antidepressant Maintenance Effectively Lowers the Risk of Recurrence of Depressive Episodes*

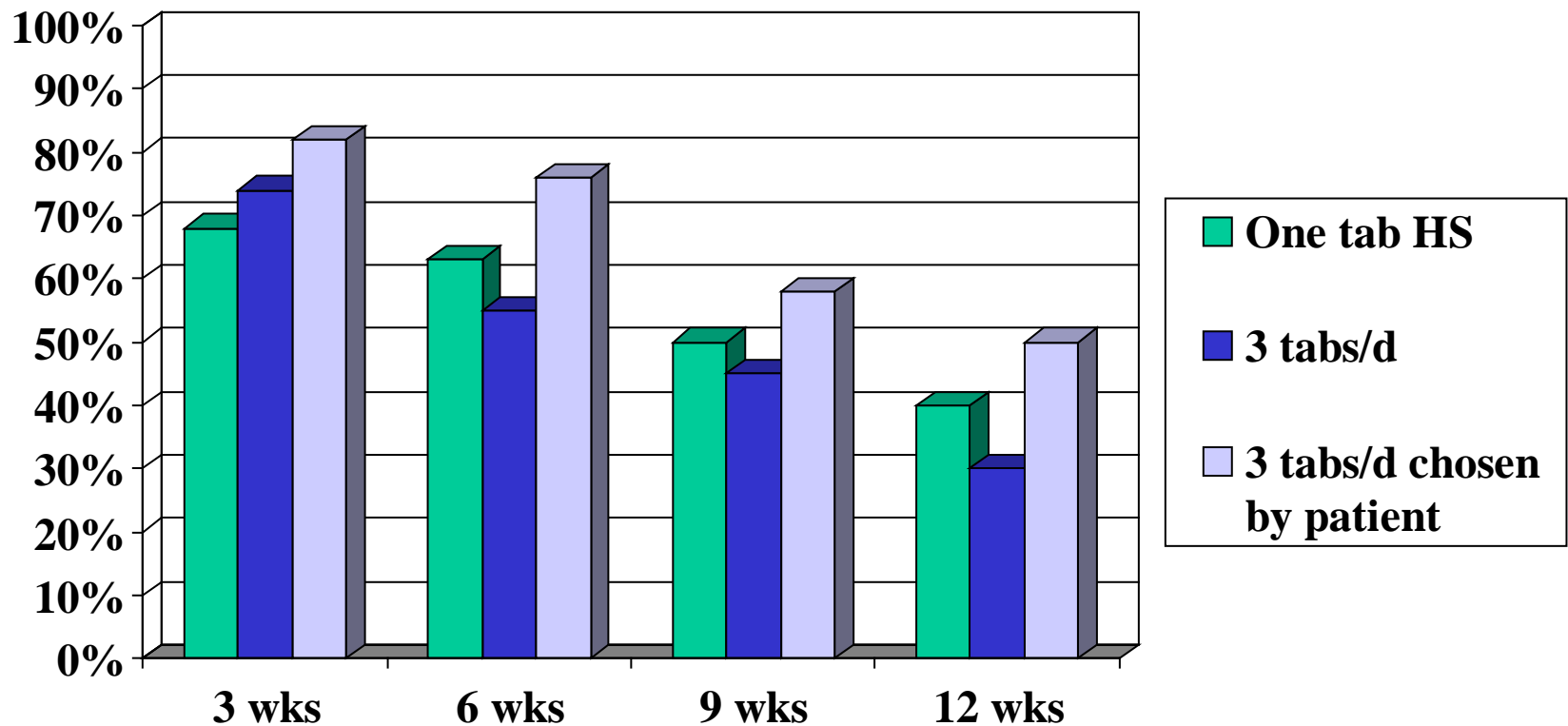


*Patients with no recurrence during a 3-year, full-dose maintenance trial were randomized to 2 years of imipramine or placebo.

Adherence: Definition and Importance

- Adherence: the degree to which a patient follows a treatment plan
- Different emphasis from “compliance”
- Limited adherence to pharmacotherapy regimens:
 - Of 750,000,000 prescriptions written in the US and UK each year, 520,000,000 go unfilled¹
 - In depression, 30% - 68% of patients discontinue antidepressant after 1 month²

Outpatient Adherence With Antidepressant Regimen Decreases with Time*



*though may be greater when patient elects regimen
Myers and Branthwaite, Br J Psychiatry 1992;160:83-6.

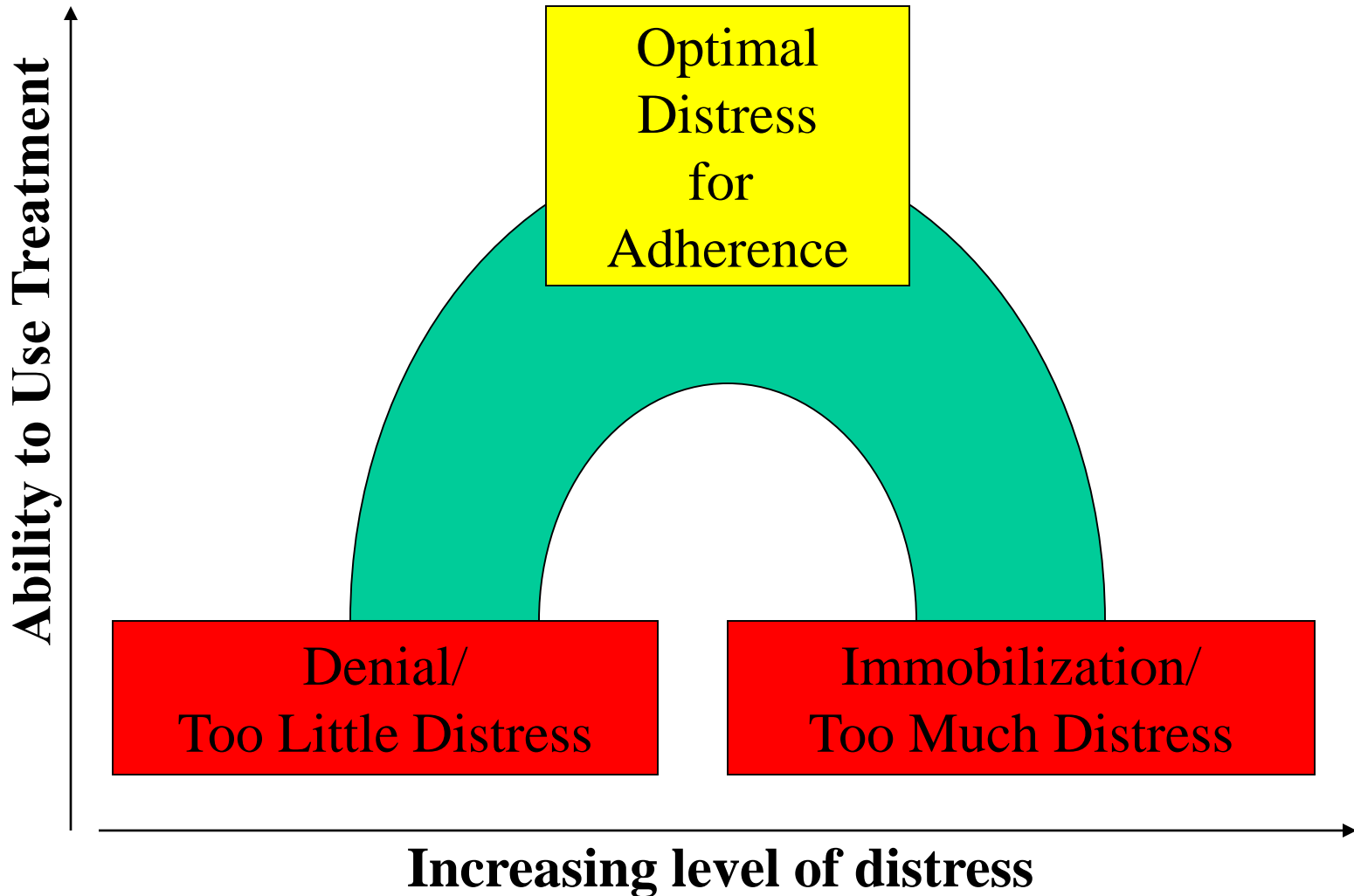
HEDIS Data Show Poor Achievement of Minimum Recommended Antidepressant Treatment Duration

- Data from 230 health plans (122,552 lives):
- 41.2% of depressed patients failed to receive 3 months of acute treatment
- 57.8% of depressed patients failed to receive 6 months of treatment

Patient and Treatment Characteristics Influence Antidepressant Regimen Adherence

- Distress/Motivation
- Medication characteristics
- Treatment accessibility
- Therapeutic Alliance

Level of Distress and Motivation



Medication Characteristics



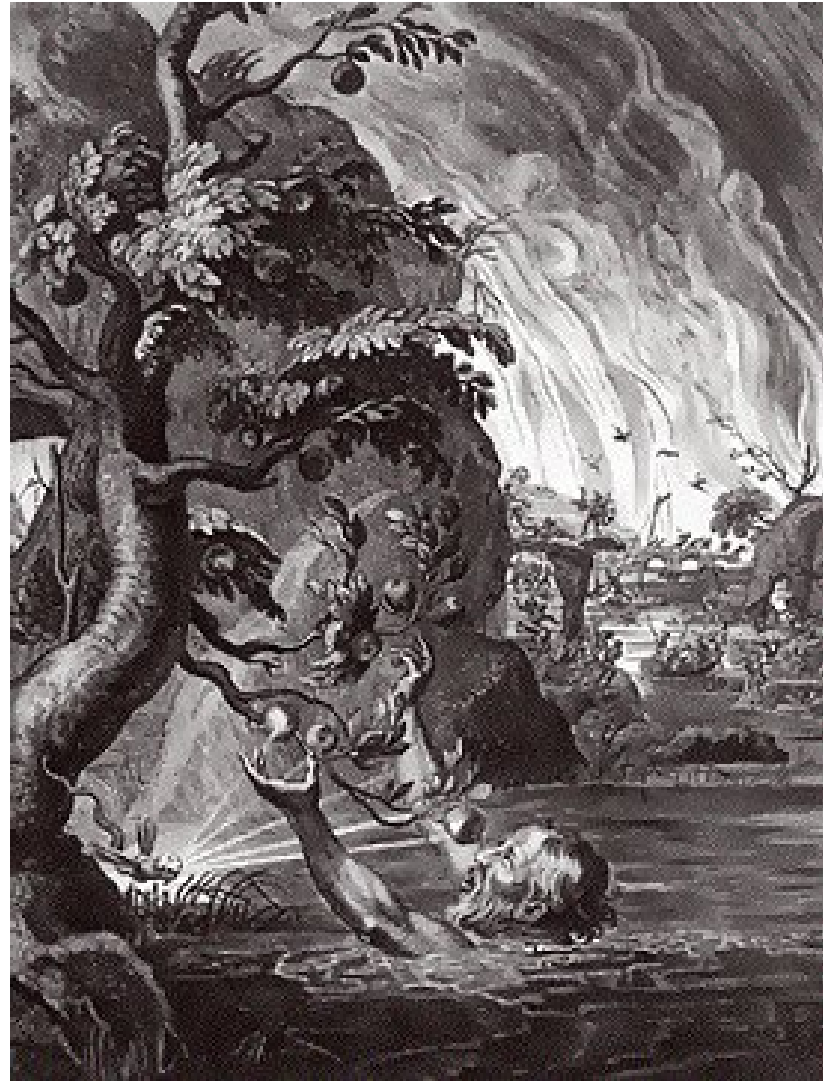
Effectiveness and Side Effects: Limitations of Current Agents

- 10%-20% of patients fail to tolerate an initial antidepressant trial¹
- Response rate in controlled trials: 55-70%²
- Typical symptom improvement: 50-75%²
- Remission: 33-50%
- Many responders live with
 - Partial improvement
 - Adverse effects

Side Effects: What **Else** Does the Antidepressant Alter?

- Sleep and Alertness
- Appetite and weight
- Motivation and energy
- Concentration, Memory, Speech fluency
- Sexual libido and performance

Treatment Accessibility



Barriers to Access

- Healthcare delivery system
 - Actual availability of treatment (e.g. phantom networks)
 - Restricted choices (e.g. push toward medications)
 - Benefit limitations (e.g. formulary choices)
 - Treatment costs (e.g. copayments or fees for service)
- Poor support group
 - Spouse, employer
- Patient's lifestyle
 - Cited as factor by patients more than by psychiatrists¹

1. Warner et al 1994

Increasing Reliance on Antidepressants in US Treatment of Depression (1987 to 1997)

- Proportion of population receiving outpatient treatment for depression has increased (0.73 to 2.33%)¹
- Antidepressant use as increased (37.4 to 74.5%)¹
- Psychotherapy (71.1 vs 60.2%) and mean number of psychotherapy visits decreased (12.6/yr to 8.7/yr)¹
- Increasing copayments for psychotherapy cited as factor in increased reliance on antidepressants.²

Therapeutic Alliance



Therapeutic Alliance

- “Collaborative bond between therapist and patient”¹
- Significantly influences treatment outcome in pharmacotherapy of depression¹
 - Holding environment
 - Enhancer of placebo effects
- Specific pharmacotherapeutic alliance
 - Safe and supportive interaction
 - Communication
 - Education
 - “Participant prescribing” vs dispensing of meds²

Rise of the “Med Backup”

- Precedents
 - Therapist/Prescriber split in psychoanalysis
 - Community Mental Health Team model
- Need for Specialization due to increased treatment options
- Resource management in managed care systems:
 - Response to patient demands
 - Efficient allocation of costly staff resources
 - Psychotherapy can be provided by range of clinicians

What Does a Psychopharmacologist Do?



Elements of a Pharmacotherapy Visit

1. Review previous records
2. Establish rapport/consent
3. Obtain interval history
4. Assess treatment response
5. Assess mental status
6. Update treatment plan
7. Educate re diagnosis and treatment
8. Address questions/concerns
9. Write prescription
10. Arrange tests/consultations
11. Schedule next visit
12. Document visit/new plans
13. Complete additional paperwork/letters
14. Liaison with other care providers/family

Why Are Brief Appointments Conducive to Poor Treatment?

- Hurried clinician will:
 - Lack knowledge of patient history
 - Lack perspective on degree of variance from baseline
 - Be hampered in forming treatment alliance
 - Lack sufficient time for observing current behavior, inquiring about adherence, or assessing treatment response
 - Tendency to increase medication number/dosages and prolong treatment if risk-averse
 - Lose professional satisfaction

What Can We Do To Increase Adherence?



1. Address Level of Distress and Motivation

- Assess patient for suitability of diagnosis/symptoms for treatment.
- Assess level of denial/motivation.
- Use motivational interviewing techniques to ally with patient around target symptoms.

2. Address Medication Characteristics

- Match regimen to patient's needs:
 - Cost
 - Simplicity/Scheduling
 - Side effect profile
- Monitor effects and side effects in ongoing way
- Offer alternatives when appropriate

3. Address Accessibility of Treatment

- Assess availability of prescriber.
- Assess affordability of care.
- How does life routine help or hinder?
- How does social support system help or hinder?

4. Strengthen the Therapeutic Alliance

“...the proper use of drugs actually depends on the existence of a psychotherapeutic relationship.”¹

A. Reduce “Hurry” through Allocation of Visit Time

Activity in “Med Check” Visit	30-Min Session	15-Min Session
Open ended questions	15	5
Follow-up questions	5	2
Specific questions regarding treatment response	3	2
Specific questions and discussion of adverse effects	2	2
Discussion of treatment plan	2	2
Patient education	2	1
Prescription	1	1

B. Listen Actively to Identify Patient Requests/Needs

“A patient may come to us saying, ‘I’m here for an antidepressant’ ... We may say, ‘Tell me about your sleep, your appetite, your interest in sex’ ... We may fail to say, ‘Tell me about your depression’ ... We need to appreciate the patient’s experience and what it means to this person”.

Silk K, quoted in Lamberg 2000

Identify Patient's Request

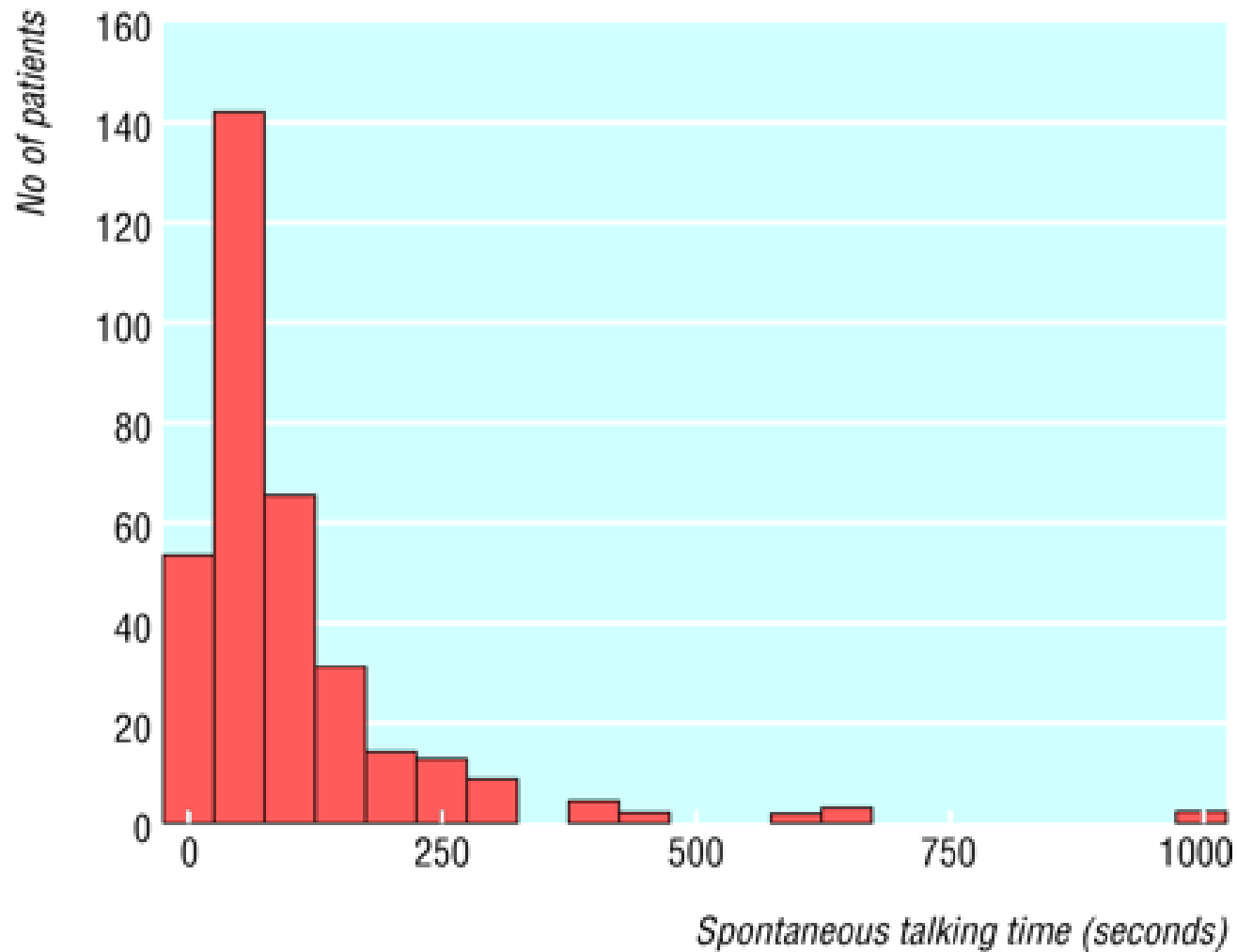
- Following 82 new psychiatric initial appointments in outpatient clinic, only 65% returned for second appointment.
- A predictor of return was patient's sense of "feeling understood in the initial session".¹
- Restating patient's request conveys shared therapeutic goals, strengthens alliance.

Allow the Patient's Spontaneous Report¹

- Average US patient in medical clinic setting is interrupted after 22 seconds¹
- Spontaneous report duration in 335 medical outpatients:²
 - Mean spontaneous talking time was 92 sec.
 - 78% of patients finished in less than 2 min.
 - Age, but not other demographics, affected this.

1. Marvel et al. JAMA 1999;281:283-7; 2. Langewitz et al. BMJ 2002;325:682-3

Spontaneous Talking Time of Outpatients



Listen to Adverse Events

- In a telephone survey of 401 Kaiser patients treated for depression, those who reported discussing adverse events with their physicians were:
 - Half as likely to discontinue therapy (0.49)
 - More than five times as likely to switch medications (OR 5.6)

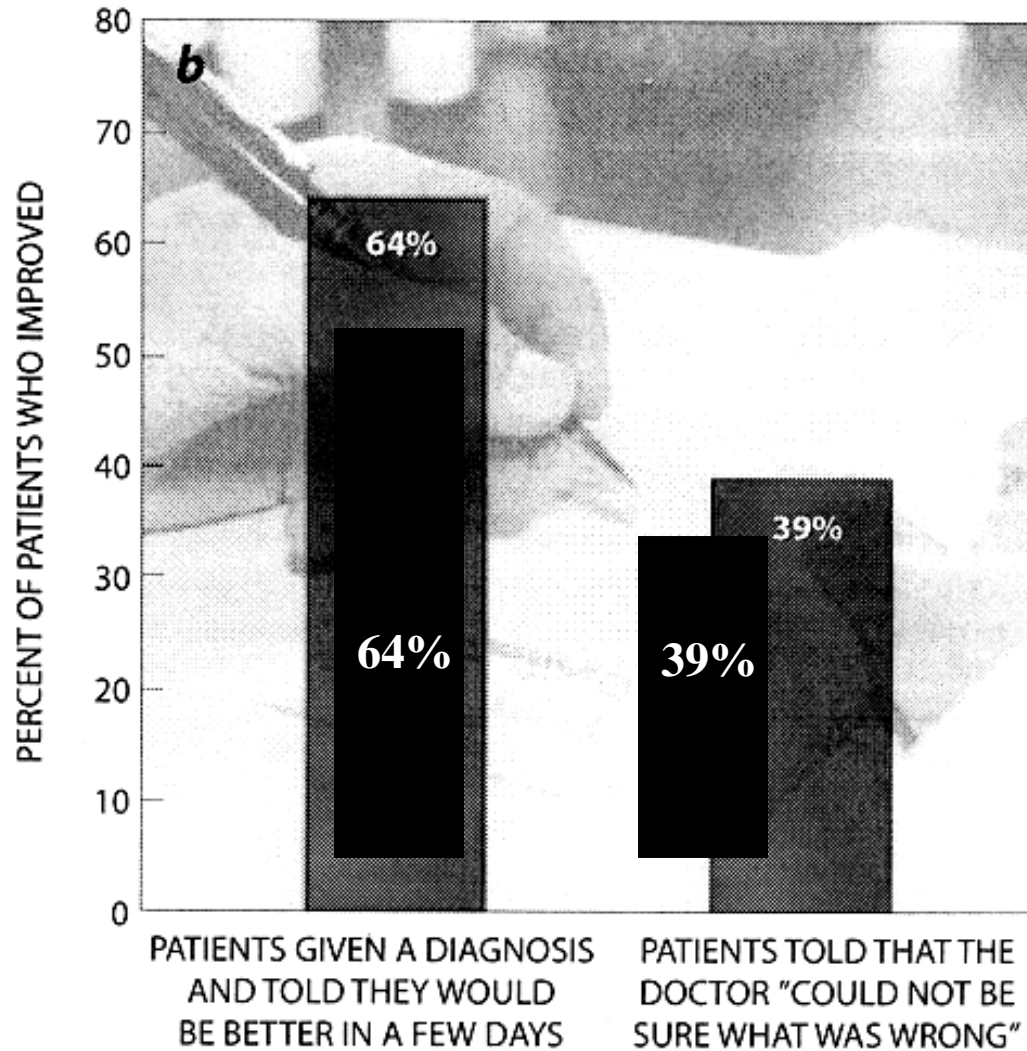
C. Harness the Placebo Effect

- Placebo effect in depression ranges from 30 to 70%¹.
- Identify a problem
- Demonstrate evidence of expertise
- Listen carefully
- Elicit patient input
- Offer limited options
- Prescribe a course of action

1. Khan and Brown 2001

Placebo Effect of “Diagnosis”

GENERIC SYMPTOMS: BENEFITS OF DIAGNOSIS ALONE



D. Offer Psychoeducation

- Name(s) of medication
- Rationale for its use
- When to take it
- What to do about a missed dose
- How to tell if it's working
- Lifestyle modifications during treatment
- Common side effects and rare serious side effects
- Expected duration of treatment
- How eventually to discontinue medication

RCT1: Psychoeducational Counseling and Reminders of Treatment Plan

- Hypothesis: Drug Counseling and/or treatment leaflet would increase antidepressant adherence and improve clinical outcome in **acutely depressed** primary care patients
- Setting: Primary care
- Subjects: 213 non-suicidal, clinically depressed outpatients

RCT1: Psychoeducational Counseling and Reminders of Treatment Plan

- “Treatment as usual”: Not described
- Intervention:
 - Informational leaflet with information on drug, unwanted effects, what to do after missing a dose
 - Counseling at weeks 2 and 8 by nurse focusing on:
 - lifestyle
 - attitudes to treatment
 - understanding reasons for treatment
 - Education about depression and resources
 - Importance of adherence

RCT1: Psychoeducational Counseling and Reminders of Treatment Plan

- Effects of Intervention:
 - **Counseling significantly increased adherence**
 - Counseling had significant positive effect on clinical outcome (SF36 MH Subscale) in patients with major depression and at least 75 mg/d of designated antidepressant (dothiepin or amitriptyline)
 - **Leaflet did not increase adherence**

RCT2: Psychoeducation, Reminders, and a Written Treatment Plan

- Hypothesis: **Relapse prevention** intervention would improve continuation and maintenance phase adherence in patients with chronic depression
- Setting: Primary care
- Subjects: 386 non substance-abusing adults with
 - <4 DSMIV major depressive symptoms
 - ≥ 3 episodes of major depressive disorder or dysthymia

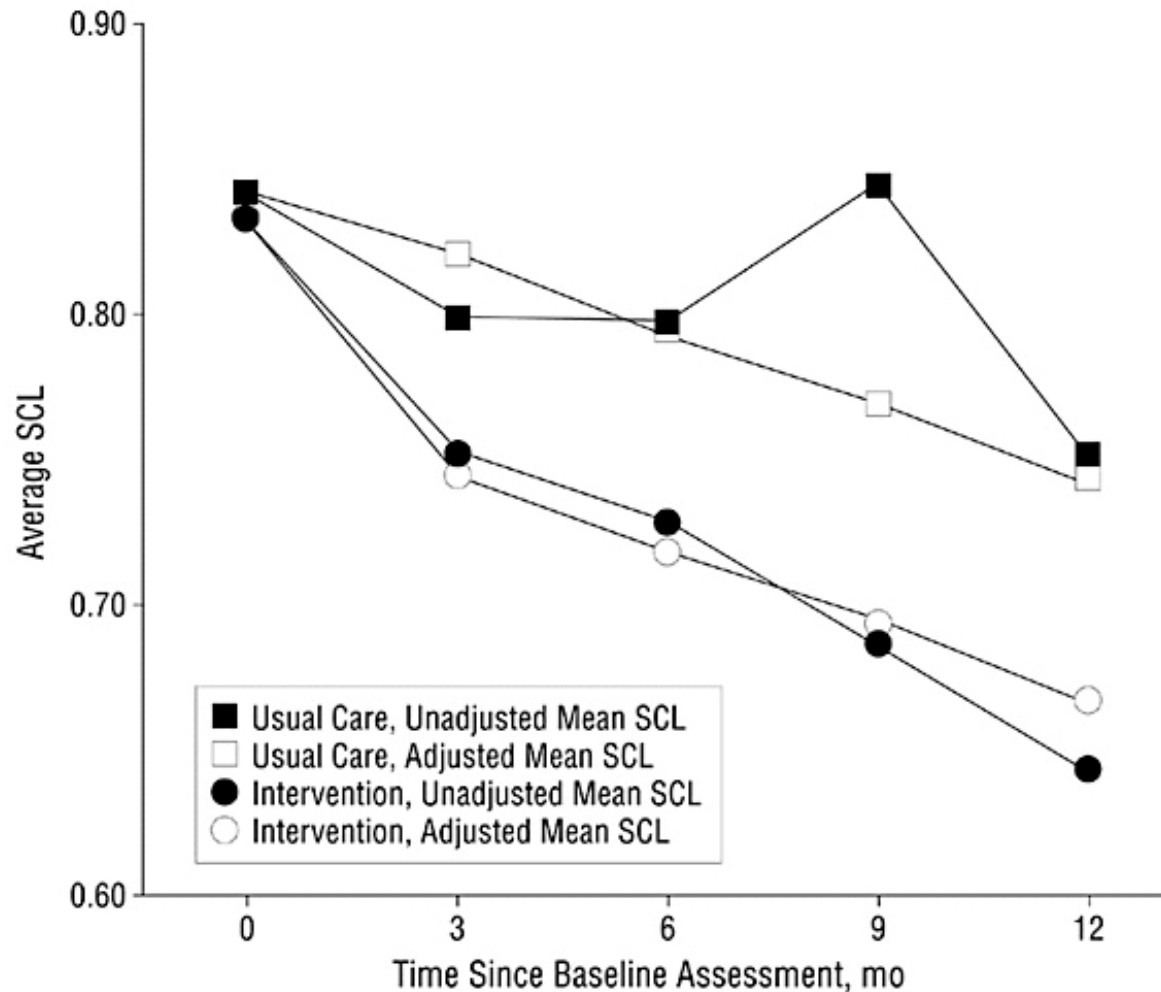
RCT2: Psychoeducation, Reminders, and a Written Treatment Plan

- Usual Care: 2-4 visits over 6 months
- Intervention:
 - Book & video tape, 2 primary care visits with depression specialist, 3 phone visits, and 4 personalized mailings over 1 year period emphasizing:
 - Adherence to antidepressant regimen
 - Recognition and monitoring of prodromal symptoms
 - Development of written relapse prevention plan
 - Clinician contact when refills missed or prodromal symptoms noted by patient on mailed checklist

RCT2: Psychoeducation, Reminders, and a Written Treatment Plan

- Effects of Intervention:
 - Decrease in depressive symptoms
 - Increased adherence to adequate antidepressant dosage (63.2% vs 49.7% at 12 months)
 - Likelihood of refilling prescription in 12 mo follow up period
 - No decrease in episodes of relapse/recurrence

SCL-20 Scores During 12-Month Relapse Prevention Intervention vs. Usual Care



Katon et al. 2001

Difference between I and UC significant at $p < 0.04$

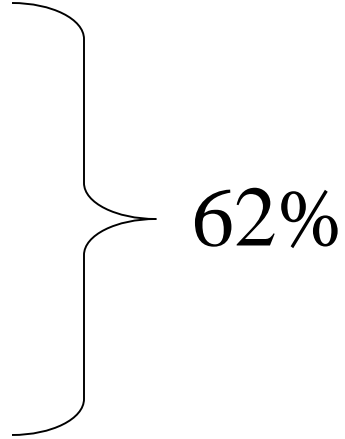
E. Monitor the Alliance

Transference to pharmacotherapist can be:

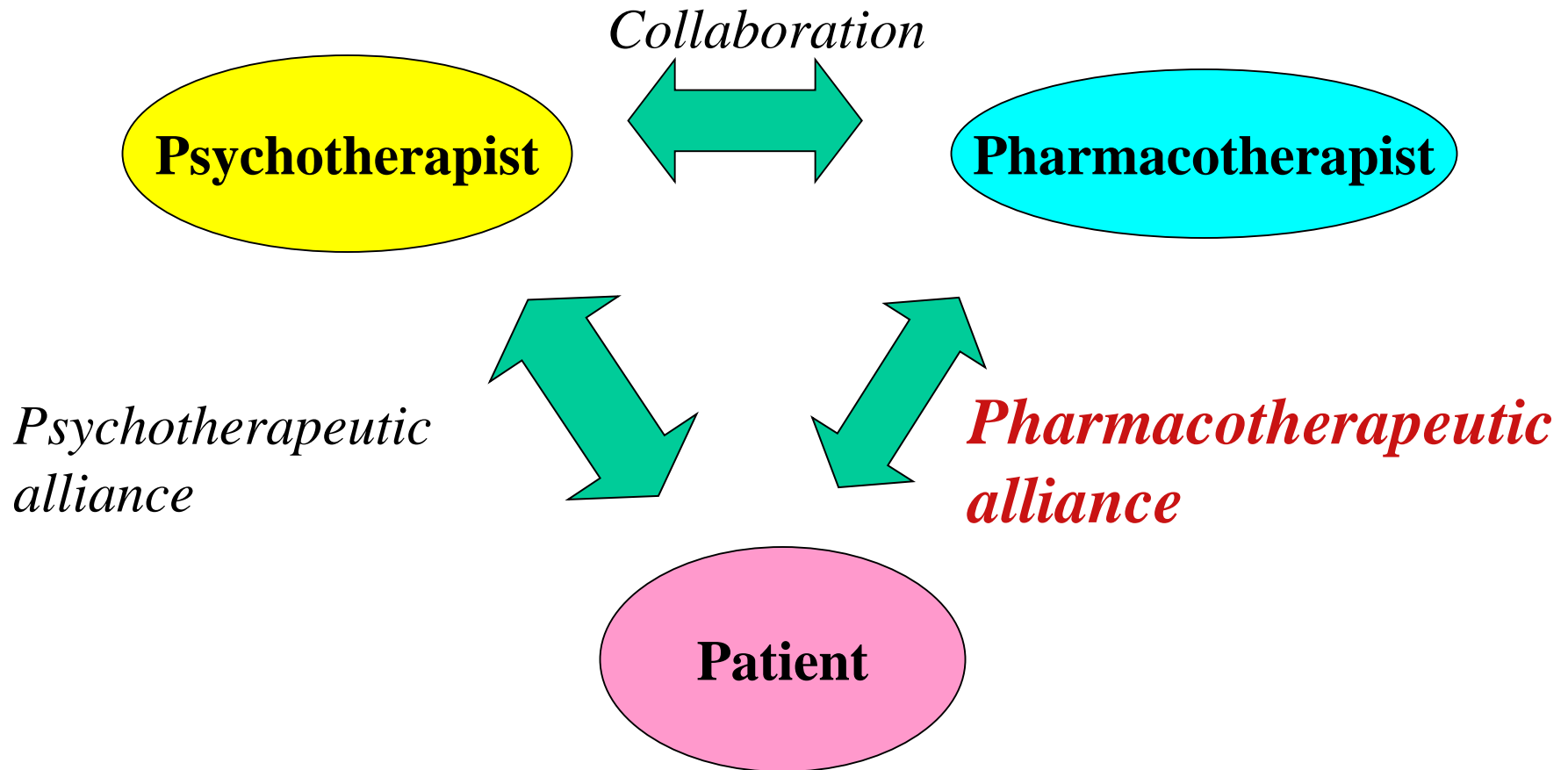
- Benevolently powerful –magical healer/nurturer
- Humane and helpful – concerned and caring
- Benign – a qualified and available technician
- Poor quality – but a forced choice
- Malevolently powerful – a controller, addicter, or poisoner

A frequent concern: *Treatment with medication can be experienced as devaluation of a person's uniqueness, of the psychosocial aspects of an illness, and of the person's own agency in recovery.*

Countertransference: Physicians' Reported Responses to Treatment Nonadherence

- Medical threat
 - Authoritarian tactics
 - Blaming/criticizing/insulting
 - Withdrawal
 - Task-oriented response
 - Trying to determine cause
 - Altering the regimen
- 
- 62%

F. In Collaborative Treatment, include other members of treatment team in alliance



Communication Tips (1): Referral Conversation

- Assess context and circumstances of request
- Obtain consent of patient for communication
- Share credentials and experience
- Discuss treatment philosophy

Communication Tips (2): Post-Assessment Discussion

- Case formulation
- Treatment approach and goals
- Implementation plans
- Mechanics of communication
 - Accessibility
 - Delineation of responsibility
 - Planning for emergencies
 - Agreement about subsequent communication

Communication Tips (3): Collaborative Relationship Maintenance

- Don't undermine or idealize treatment/clinician
- Maintain respectful communication as needed
- Address conflict early
- Use consultant when appropriate
- Dissolve collaboration, without abandonment, when necessary
- Patient care is first priority

G. Resist erosion and narrowing of the psychiatrist's treatment role

- Role/professional identity is increasingly determined by extrinsic factors
- Role satisfaction suffers with narrowing of scope of activity
- “Cost effectiveness” argument is used to support specialized use of psychiatrists and treatment disaggregation

Study 1: Are Psychiatrists Cost Effective?

- Method:
 - Seven insurer's fee schedules from 1999 were used
 - Several clinical scenarios were compared for cost
 - 1) Combined treatment
 - 15 T + 10 M, 10 T + 5 M, 5 T + 3 M
 - Psychotherapy provided by psychiatrist, psychologist, social worker
 - 2) Medication management: 10 M, 5 M, 3 M
 - 3) Psychotherapy alone: 15 T, 10 T, 5 T

Study 1: Are Psychiatrists Cost Effective?

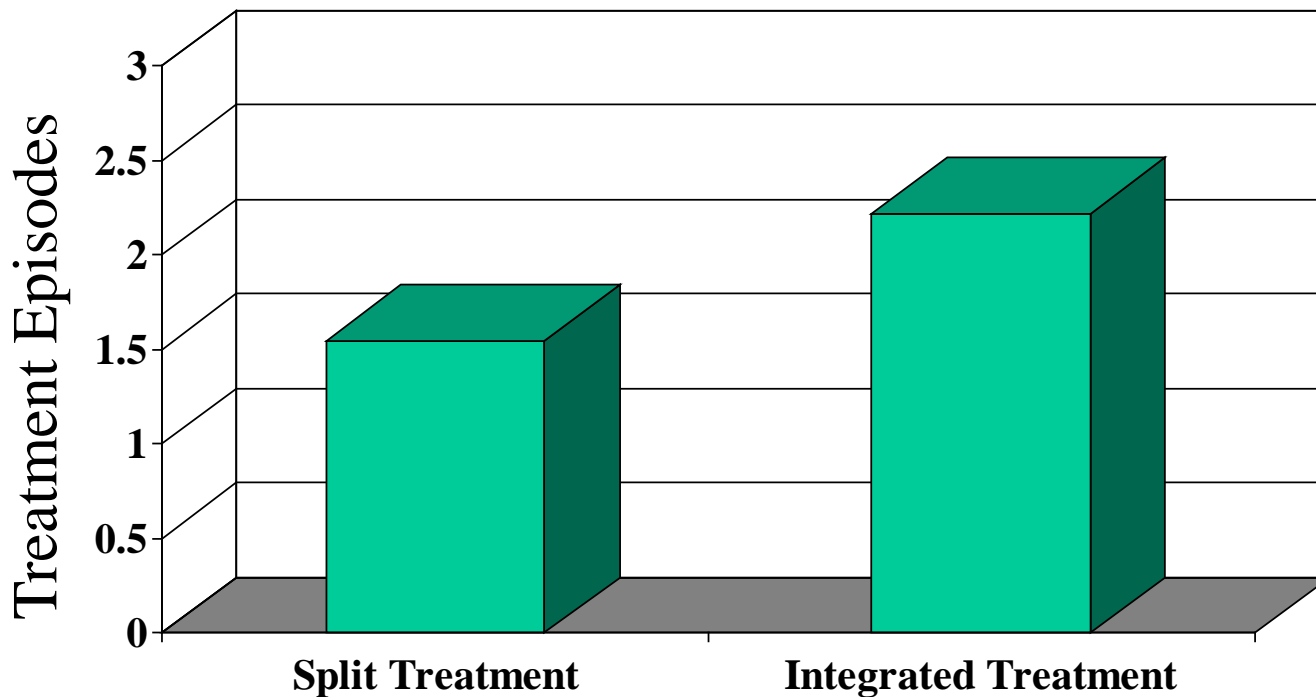
- Results:
 - Medication management alone was least costly.
 - Psychotherapy by MSW cost less than PhD, which cost less than psychotherapy by MD.
 - For patients in combined treatment, psychiatrist providing both modalities cost significantly less than MD/PhD split, a little less than MD/MSW split.

Dewan 1999

Study 2: Is Integrated Treatment More Cost Effective than Split Treatment?

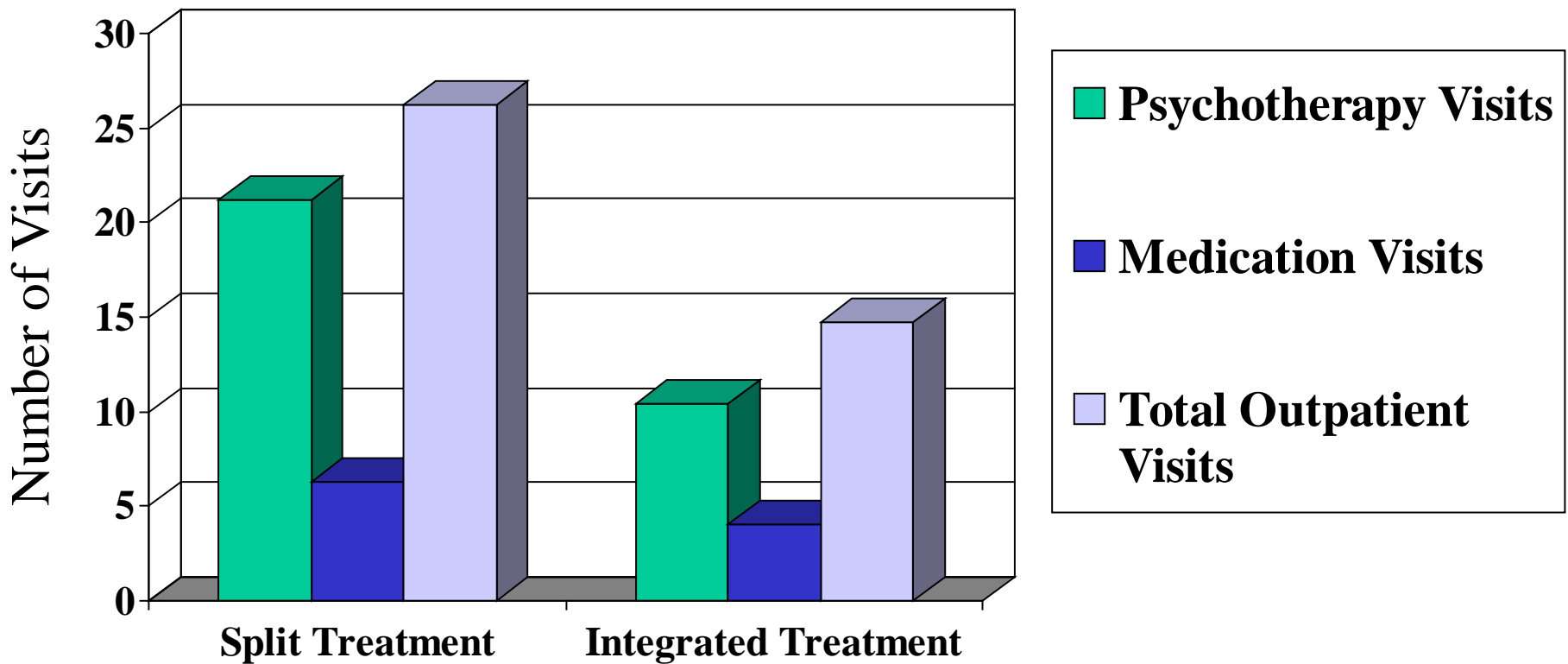
- Methodology of Goldman et al:
 - Retrospective comparison of claims data for 18 month period
 - USBH (managed mental health organization)
 - Compared patients in integrated vs. split treatment
 - Diagnoses:
 - Major depression
 - Dysthymic Disorder
 - Depressive Disorder NOS
 - Mood Disorder NOS

Integrated Treatment Occurred in More Episodes



$P < 0.001$

But Total Number of Visits Was Less with Integrated Treatment



$P < 0.001$

Conclusion: Integrated treatment costs less because it is more efficient

- Fewer total visits occurred during study period.
- Split treatment lacks efficient coordination of treatment modalities.
- Medication is initiated earlier in integrated treatment, preventing inefficient delays.
- Sessions spaced further apart makes for greater efficiency in use of services provided.

Conclusions

- Adherence is an important element of treatment success in depression.
- Multiple factors including the therapeutic alliance affect adherence.
- The therapeutic alliance can be improved by:
 - Creating an unhurried but efficient atmosphere
 - Listening actively to identify patient requests/needs
 - Harnessing the placebo effect
 - Providing psychoeducational counseling
 - Monitoring the treatment alliance
 - Including collaborative treaters in alliance
 - Resisting erosion/narrowing of psychiatrist's role

Citations:

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The End

Post Lecture Exam

Question 1

1. **Depression's disabling features include which of the following?**
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 - B. Recurrent of episodes
 - C. Increased mortality from suicide and some medical disorders
 - D. Side effects of antidepressant medications
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 - B. Intolerable or unacceptable treatment regimens due to cost, pill characteristics, or dosing schedule
 - C. Difficulties in assessing treatment or contacting providers
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Answers to Pre & Post Competency Exams

1. E
2. A
3. E
4. A
5. E