MAINTAINING THE ALLIANCE IN MODERN PEDIATRIC PHARMACOTHERAPY PRACTICE

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Goals of this presentation

- By the end of this lecture, participants will be able to discuss the following questions:
  - How does the therapeutic alliance differ in clinical work with children and teens, compared to that 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?

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 therapeutic alliance. In: Tasman A, Riba MB, Silk KR, eds. The doctor-patient relationship in pharmacotherapy: Improving treatment effectiveness. NY: Guilford;25-47.

Essential Components of the Alliance

- The collaboration between therapist and client involves three essential components: *tasks, goals,* and *bonds*. (Bordin, 1979, 1994)
  - *Tasks* are the in-therapy behaviors and cognitions that form the basis of the therapeutic process
  - A strong working alliance involves both therapist and patient mutually endorsing and valuing the *goals* (outcomes) that are the targets of an intervention
  - The *bond* acknowledges patient-therapist attachment status, and includes mutual trust, acceptance, and confidence

Working Alliance

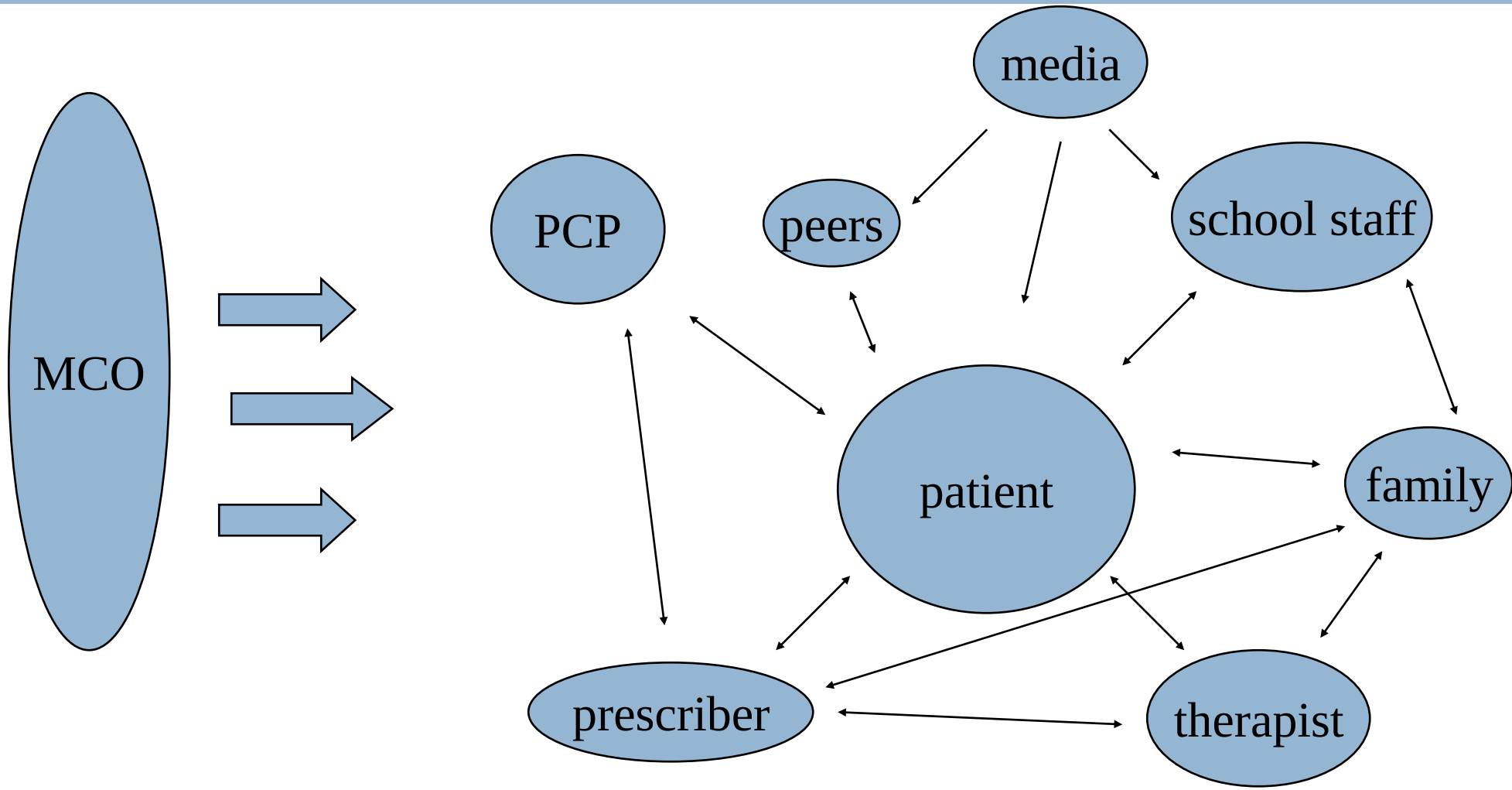
- A strong working alliance has, at its core, the concept of *mutual collaboration against* the common foe of the patient's presenting problem(s).

- Related terms, "helping alliance", "therapeutic alliance"

Rationale and Theory for studying the Alliance

- All aspects of our work have psychological meaning to patients and families (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)
- We must be able to retain our abilities as *therapists* in all that we do

Factors Affecting the Alliance



Adapted from Carli, 1999

Rationale and Theory for importance of this approach

- Therapeutic Alliance in Child Mental Health
  - The collaborative bond between therapist and patient
    - And parent!
- Recognized across paradigms as a cornerstone of effective treatment
- The offer of treatment as a non-neutral act
- Soon to be a measurable psychotherapy skill in training programs (Kay, 2001; ABPN 2007)

Empiric Support

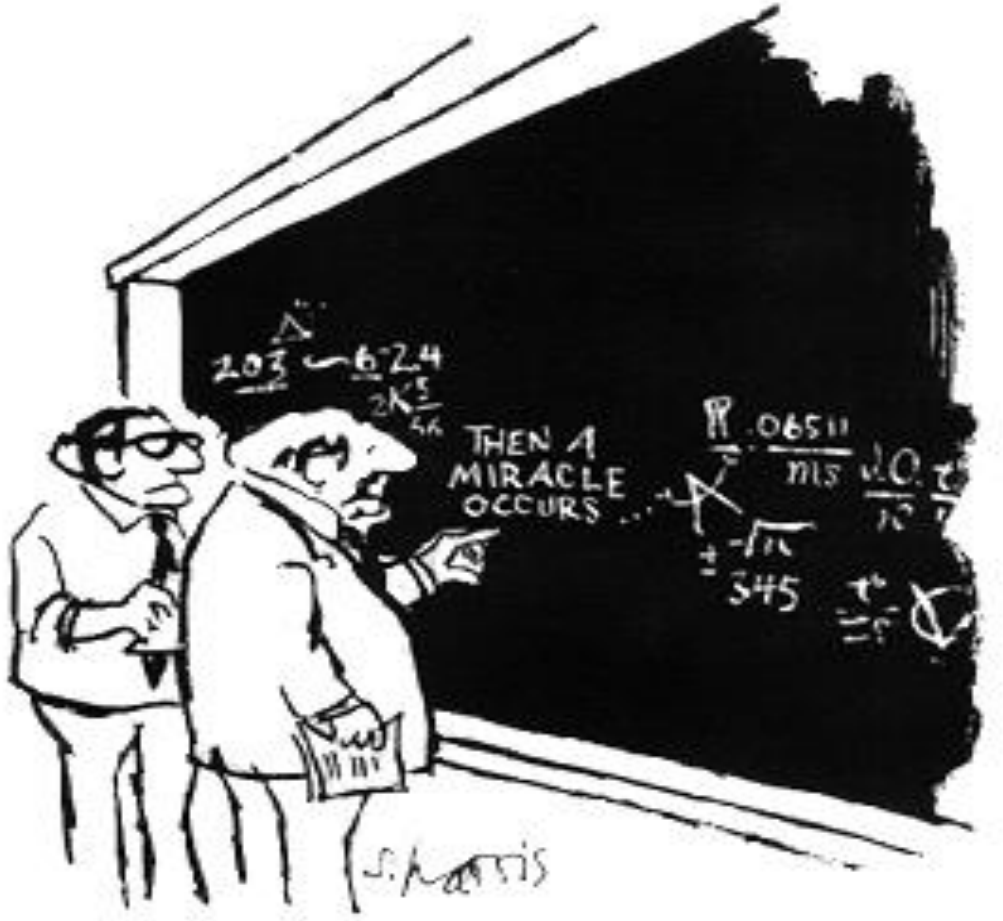
- Therapeutic Alliance in psychotherapies
  - Much empiric support for its relevance and relationship to positive outcomes across all therapies (Children, Teens and Adults)
- Therapeutic Alliance in pharmacotherapies
  - Empiric support now growing
- Therapeutic Alliance in pharmacotherapies with children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

Empiric Support

- 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)

- Therapeutic Alliance Measures (Children and Teens)
  - Therapeutic Alliance Scales for Children, Teens (TASA, TASC; Shirk, et al. 1992)
  - The Revised Helping Alliance Questionnaire (HAq II), Luborsky L, et al. 1996)

Empiric Support



"I think you should be more explicit here in step two."

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
  - Predicts outcome with modest success (ES=0.21-0.30)

Empiric Support

- Specific variables:
  - interpersonal skills (expressed responsiveness and the ability to generate a sense of hope)
  - open and clear communication style
  - emoted empathy
  - 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
  - Differences in pharmacotherapy vs. psychotherapy vs. integrated yet to be investigated
  - MTA and Alliance
    - Collaborative work group (Stanford, University of Cincinnati, REACH Institute) assessing early vs. late alliance in parents enrolled in the medical management group, behav group, combined treatment group

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
  - Pharmacotherapist perception of alliance compared to patient perception

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. *J Consult Clin Psychol*;** 64(3):532-39
  - Adult study; N=225; prospective trial, multiple therapies
    - IPT, CBT, Imipramine+clin management, Placebo+clin management

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) : Alliance alone appeared to strongly influence the placebo response.

NIMH-TDCRP study, cont'd:

- ***"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)

Empiric Support

- In pediatrics: Dual alliance
- Parents as Partners (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

- 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

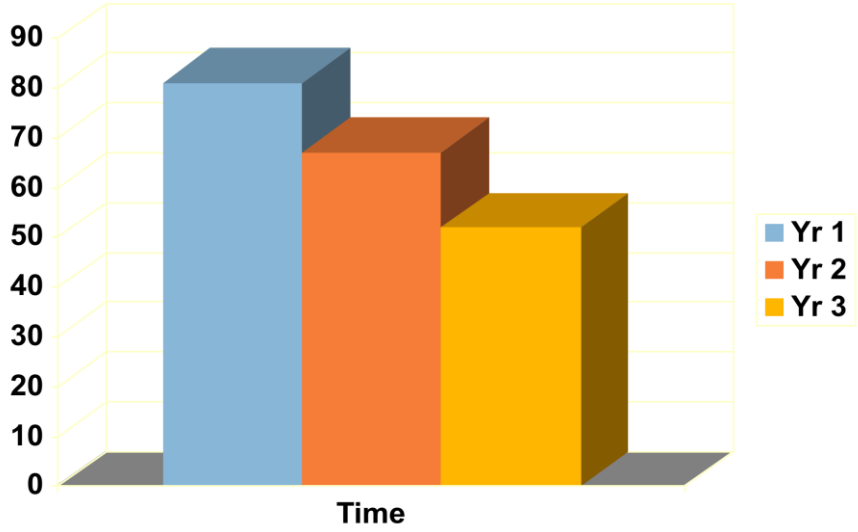
- Nevas, et al (2001)
  - Parents, in general, experience primarily positive attitudes and feelings about their child's therapist, with tendencies to feel hopeful, understood, and grateful
- Shirk and Karver (2003)
  - Caregiver alliance with their child's therapist can help predict clinical outcome

Empiric Support

- Moderators and mediators of long-term adherence in children and teenagers with ADHD;

  Thiruchelvam, et al, ***JAACAP***, 40 (8); 2001

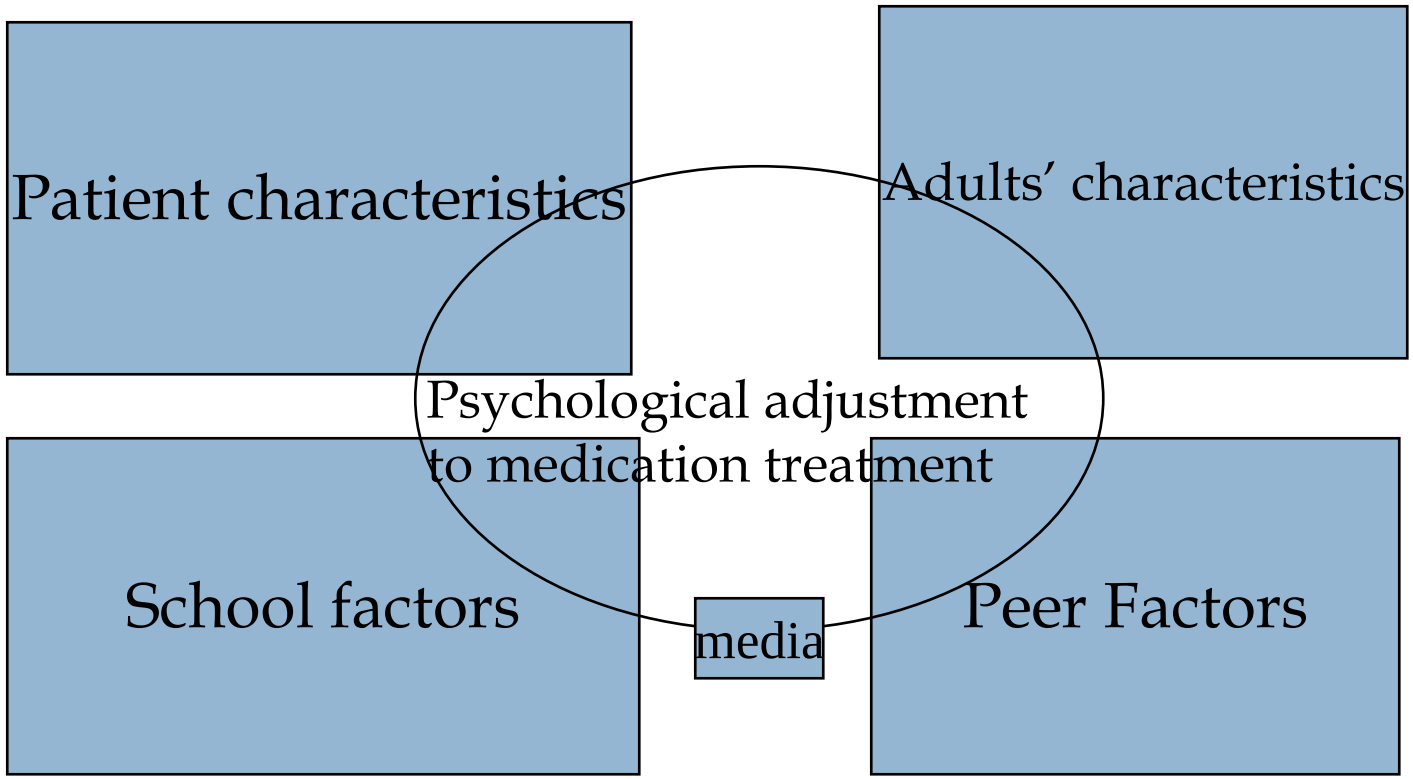
  - **N=71; ages 6-12 yrs;** prospective PBO-controlled trial, 12-month tx, then 2 year follow-up
  - **Measures:** Treatment Monitoring Questionnaire **(TMQ)- for parents, teachers**
    - Child Satisfaction Survey **(CSC)- for children**
- Adherence rates : 81% yr 1, 67% yr 2, and *52% yr 3*



Empiric Support

- Thiruchelvam, et al ***JAACAP***, 40 (8);2001,922-28 continued
  - Moderators of positive adherence:
    - More teacher-rated severity of ADHD
    - Absence of ODD in school
    - Younger age at baseline
  - Mediators of adherence
    - 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

Factors affecting adjustment to medication treatment



Integrated Treatment

- Defined as the combined use of psychoactive medication and psychotherapy (Pruett & Martin, 2003; Schowalter, 1989; Steiner, et al. 2004))
- Components
  - The meaning of the medication itself, and on the self
  - The decision to offer medication
  - How and when to present the idea
  - The act of writing and giving the prescription

Integrated treatment and Pharmacotherapy

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

The meaning of the medication itself, and on the self

- Children may have very interesting and relevant ideas about what medication is used for, and why they are “in treatment” or “being medicated”

Children, Medication and Meaning

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**

Adapted from Pruett, Joshi & Martin, 2010 (in press)

Children, Medication and Meaning, 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 may be seen as the doctor's "agent", rather than as an ally of the child

Adapted from Pruett, Joshi & Martin, 2010 (in press)

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
  - Others worry that self perceptions will be altered

    "I love my symptoms, Doc, they make me myself!"

    (Pruett & Martin, 2003; p.418)

Backhanded compliments; Using session to educate parents about this

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

- "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

How and when to present the idea

- 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
- 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 directed primarily to them
    - Other option—"Who shall I give this to?"

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
  - Especially prevalent in University clinics

Medication Adherence

- In adult and child studies, adherence to medication depends on :
  - The working relationship with the prescriber
  - The transference and counter-transference relationships with the prescriber
  - The interventions being used
    - Ease of use
    - Side effects
  - The "relationship" that the patient carries on with the pills themselves (Ellison, 2000)
- Improved alliance and adherence lead to better outcomes (Brown and Sammons, 2002a)

Psychologic analgesics (Havens, 2000)

- 1) *Protecting 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) *Emoting 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) *Providing 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*."

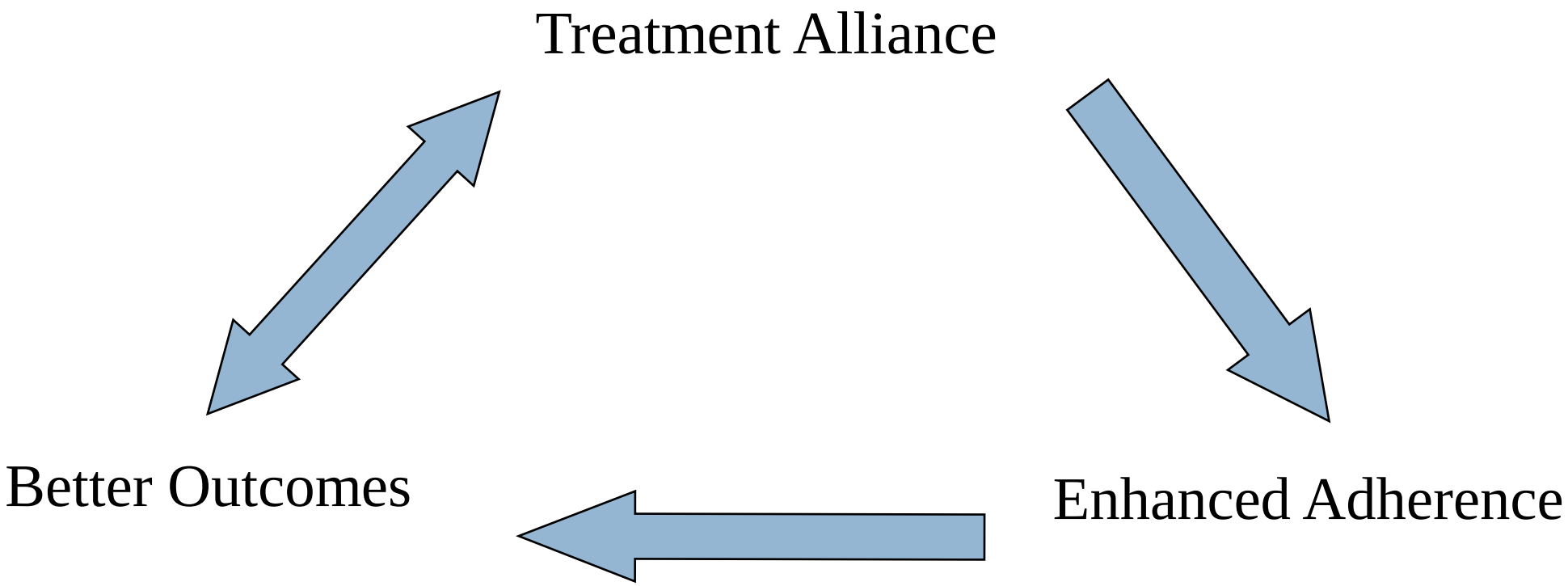
Stanford Specialty Clinic experiences

- 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)
  - Faculty, Trainees and Staff actively solicit opinions and get information from parents regarding what they're reading and which Internet sites they visit

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



Future Directions

- Creation of a new instrument, the TAPPS
  - The Therapeutic Alliance in Pediatric Pharmacotherapy Scale (TAPPs- Joshi, 2006)
    - Three existing, valid questionnaires are being studied as models
      - Therapeutic Alliance Scale in Children/Adolescents (TASA, TASC); Shirk, et al. (1992)
      - California Pharmacotherapy Alliance Scale (CALPAS); Weiss, et al. (1997)
      - Helping Alliance questionnaire for child psychiatry HAq-CP, Kabuth , et al. (2003)

Future Directions

Examples of parent items:

- I felt that the doctor "pushed" us to start medication for my child
- The doctor and I agree on the best way to help my child
- I tell my child to keep the medication a secret from others

Future Directions

Examples of teacher items:

- I understand why medication has been recommended for this child
- My observations were a valued part of the assessment process
- I feel free to contact this child's doctor to discuss my concerns

Future Directions

Examples of child/teen version :

- I understand why medication has been recommended for me
- My doctor and I agree on the best way to help me
- It is not easy to talk with my doctor
- My doctor talked about the medication in a way I could understand

Future Directions

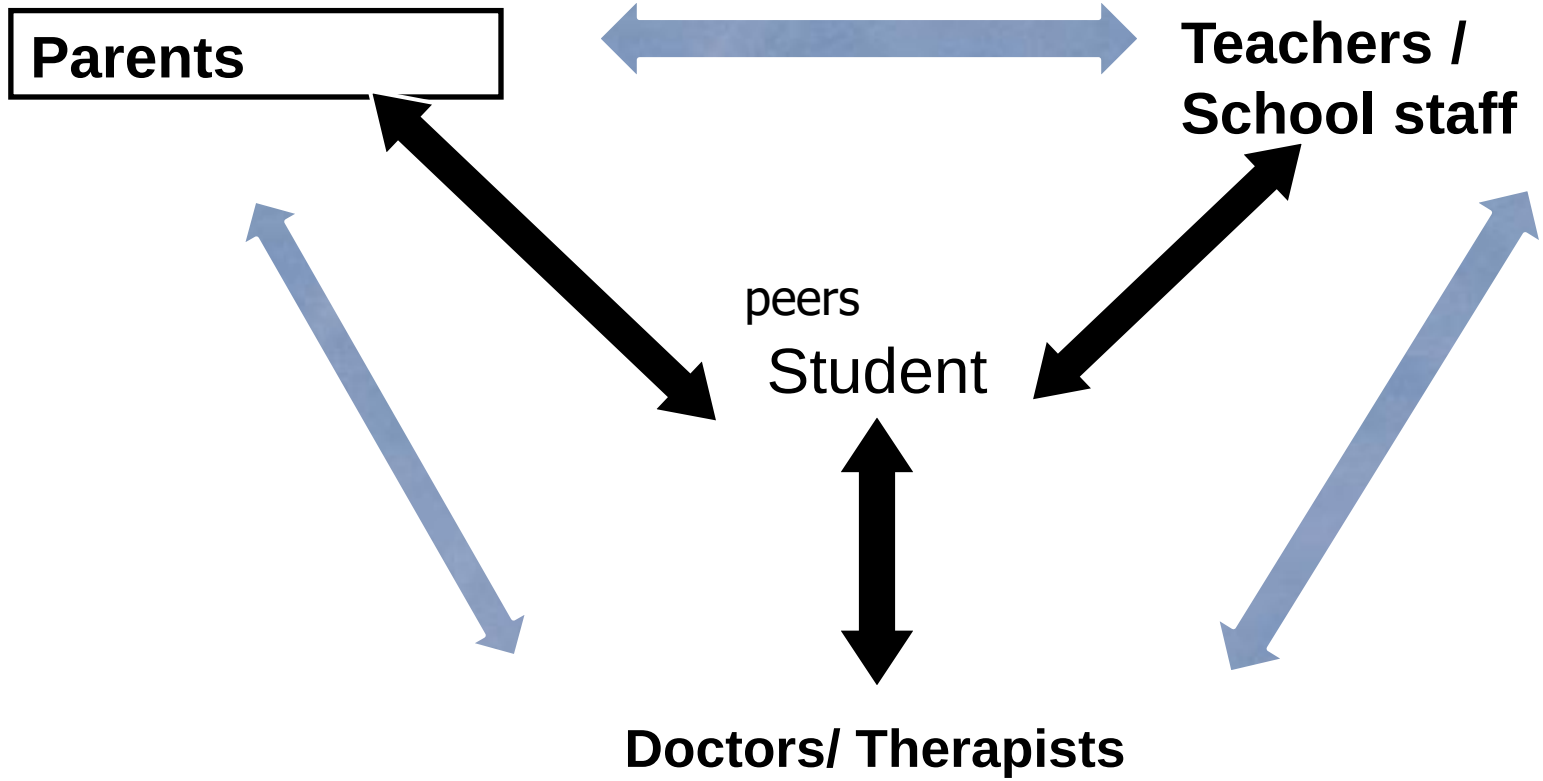
***Goals for the new combined instrument*:**

- 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
- Among the first alliance scales to include a teacher component

The Supporting Alliance in School Mental Health

- Background
  - Schools are the primary providers of mental health services for children (Hoagwood, 2007)
    - 1st line providers by *default*
    - Better if by *design*
  - Among children who receive services, 75% get them in schools 25% get treated in the general medical sector (Bums, et al., 1995; Hoagwood, 2007)

Primary therapeutic relationships



Adapted with permission from Feinstein, Fielding, Udvari-Solner, & Joshi: *American Journal of Psychotherapy*, 63(4) 2009, *319-344*

The Supporting Alliance in School Mental Health

- Research Strategies
  - Develop Interprofessional Collaboration Models
    - Teachers
      - Enhance *instructional tolerance*
    - Parents and doctors
      - Enhance alliances with other important adult figures in child's life
        - Especially the Teachers and other school staff

The Role of Collaboration

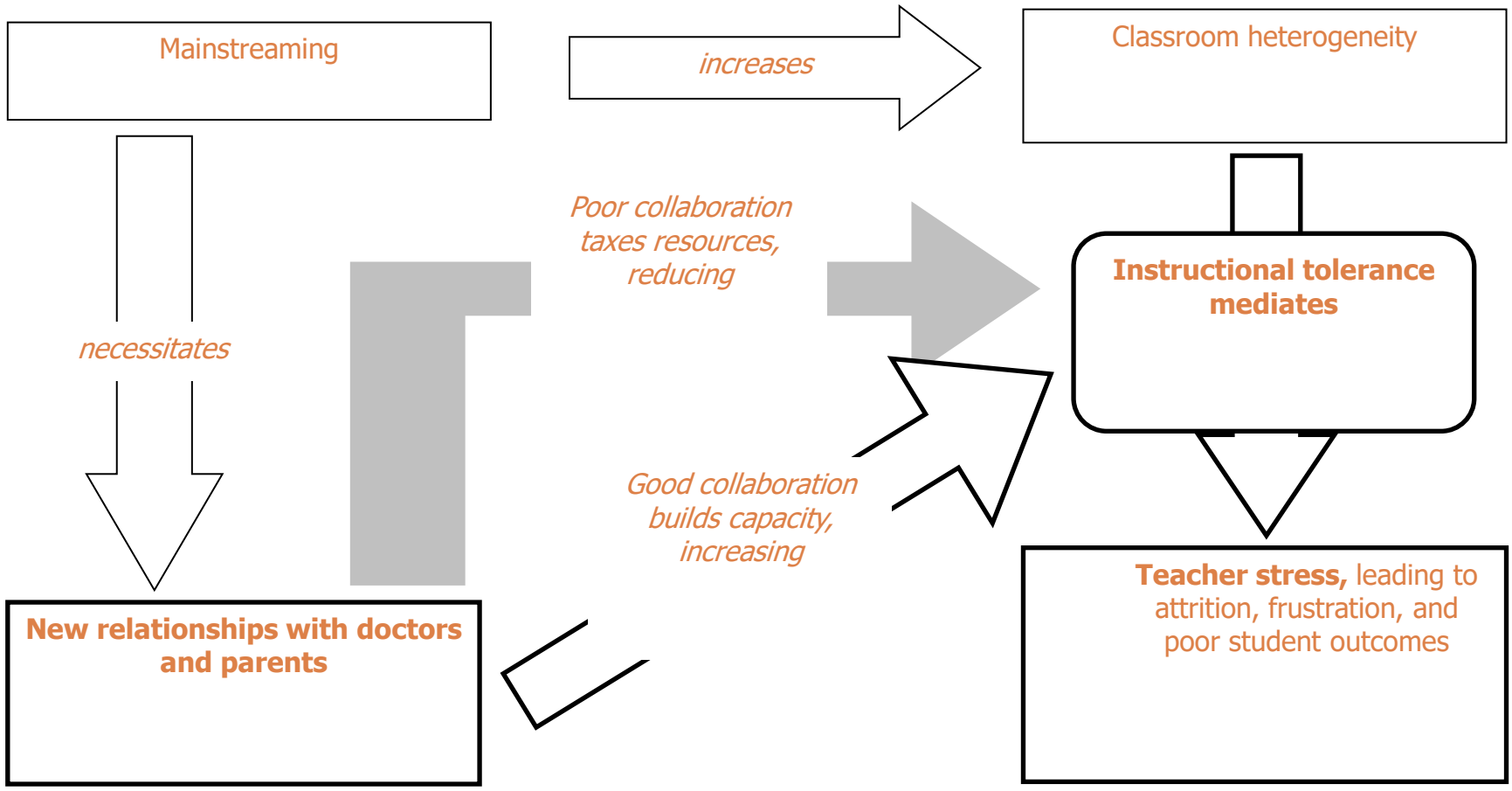


Figure 1 – Influence of collaboration on instructional tolerance
Feinstein, Fielding, Udvari-Solner, & Joshi, American Journal of Psychotherapy, 63(4), 2009, 319-344,

Conclusions

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

Blackwell, 1973, *p.252*

Conclusions

- 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 mental illness, and the meaning of medication for the patient and family
- The case formulation should be the prerequisite to the prescription, and not vice versa

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. 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
- Be mindful that getting better may be threatening to the patient

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***

Collaborators and Mentors:

- Therapeutic Alliance in Pediatric Psychopharmacology
  - Christine Blasey, PhD (Stanford Department of Psychiatry)
  - Krista Fielding, MD (Fellow, Stanford Div of Child & Adolescent Psychiatry)
  - Bernard Kabuth, MD (Universitary Hospital, Vandoeuvre, France)
  - Stephen Shirk, PhD (Univ of Denver)
  - Margaret Weiss, MD, PhD (Univ of British Columbia)
  - Kyle Pruett, MD (Yale Child Studies Center)
  - Andrés Martin, MD, MPH (Yale Child Studies Center)
- MTA Study and Working Alliance
  - Christine Blasey, PhD (Stanford Department of Psychiatry)
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  - Jeffrey Epstein, PhD (Univ of Cincinnati)
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- Supporting Alliance in School Mental Health
  - Noah Feinstein, PhD (University of Wisconsin)
  - Krista Fielding, MD (Fellow, Stanford Div of Child & Adolescent Psychiatry)
  - Alice Udvari-Solner, PhD (Stanford School of Education)

References:

- Pruett K, Joshi SV & Martin A: Thinking about prescribing, *in:* Pediatric Psychopharmacology, Principles and Practice, 2nd ed 2010 *in press*; NY, Oxford University Press

- Joshi SV: The therapeutic alliance in pharmacotherapy with children and teenagers, *in:* Martin A & Bostic J (eds.), *Child & Adolescent Psychiatry Clinics of North America,* 2006; Vol 15 ; 239-264

- Martin A, Scahill L, and Lewis O: Psychopharmacology, *in: Child Adol Psych Clin North Amer* 9(1), Jan 2000

References:

- Hawley K, Weisz J :Youth versus parent working alliance in usual clinical care: distinctive associations with retention, satisfaction, and treatment outcome. *J Clin Child Adolesc Psychol*. 2005;34(1):117-28.

- DeChillo N, Koren P, Schultze K. From paternalism to partnership: family and professional collaboration in children's mental health. *American Journal of Orthopsychiatry*. 1994;64:564-576.

- Gabbard G, Kay J. The fate of integrated treatment: whatever happened to the biopsychosocial psychiatrist? *American Journal of Psychiatry*. 2001;158:1956-1963.

- Havens L. Forming Effective Relationships. In: Havens L, Sabo A, eds. The Real World Guide to Psychotherapy Practice. Cambridge, MA: Harvard University Press; 2000:17-33.

References:

- Horvath A. Research on the Alliance. In: Horvath A, Greenberg L, eds. The Working Alliance: Theory, Research, and Practice. NYC: John Wiley & Sons; 1994:314.
- Sabo A, Rand B. The relational aspects of psychopharmacology. In: Sabo A, Havens L, eds. The Real World Guide to Psychotherapy Practice. Cambridge, MA: Harvard University Press; 2000:34-59.
- Krener PK, Mancina RA. Informed consent or informed coercion? Decision-making in pediatric psychopharmacology. *Journal of Child and Adolescent Psychopharmacology*. 1994;4:183-200.
- Mintz D. Meaning and medication in the care of treatment-resistant patients. *American Journal of Psychotherapy*. 2002;56(3):322-338.

References:

- Bordin E. The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy: Theory, Research, and Practice.* 1979;16:252-260.
- Bordin E. Theory and Research on the Therapeutic Working Alliance: New Directions. In: Horvath A, Greenberg L, eds. The Working Alliance: Theory, Research, and Practice. NYC: John Wiley & Sons; 1994:304.

References:

- Horvath A, Greenberg L. Development of the Working Alliance Inventory. In: Greenberg L, Pinsof W, eds. *The Psychotherapeutic Process: A Research Handbook*. NYC: Guilford Press; 1987.
- Oetzel K, Scere D. Therapeutic engagement with adolescents in psychotherapy. *Psychotherapy: Theory, Research, and Practice*. 2003;40(3):215-225.
- Castonguay L, Constantino M. Engagement in psychotherapy: factors contributing to the facilitation, demise, and restoration of the working alliance. In: Castro-Blanco D, ed. *Treatment engagement with adolescents*. Washington, DC: American Psychological Association; 2005

References:

Summers R & Barber J: Therapeutic Alliance as a Measurable Psychotherapy Skill; *Academic Psychiatry*, 27:3, Fall 2003

Weiss M, et al : The role of the Alliance in the Pharmacologic Treatment of Depression; *J Clin Psychiatry,* 58:5, May 1997

Schowalter J: Psychodynamics and Medication; *J Am Acad Child Adolesc Psychiatry*, 28:5; 681-684, 1989

Shirk S, Karver M: Prediction of treatment outcome from relationship variables in child and adolescent therapy: a meta-analytic review; *J Consult Clin Psychol* 2003;71(3):452– 64.

Tasman A, et al.: The Doctor-Patient Relationship in Pharmacotherapy ; NYC: Guilford Press, 2000