Teamwork: The Therapeutic Alliance in Pharmacotherapy with Children and Teenagers

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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 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?

Question 1

- According to Thiruchelvam, which of the following are moderators of increased adherence to ADHD medications?
  - A- More teacher-rated severity of ADHD
  - B- Presence of ODD in school
  - C- Older age at baseline
  - E- Female Gender

Question 2

- Which one of the following therapist behaviors has been shown to adversely affect the therapeutic alliance?
  - A- a “relaxed” approach in the early phases
  - B- a therapist whom the client experiences as “too warm”
  - C- premature insight or interpretation
  - D- therapist neutrality
  - E-None of the above

Question 3

- Which of the following was true about the alliance in pharmacotherapy, according to the TDCRP (Treatment of Depression Collaborative Research Program)?
  - A- The strength of therapeutic alliance can influence the outcome of pharmacotherapy
  - B- The CBT skills of the therapist was the most predictive of the clinical outcome in pharmacotherapy
  - C- The imipramine-treated group had better clinical outcomes than the CBT-treated group
  - D- The alliance was measured without observing the doctor-patient interaction

Question 4

- Which of the following is NOT a “psychologic analgesic”, as described by Havens ?
  - A- Protecting self-esteem
  - B- Providing a sense of future
  - C- Emoting a measure of understanding and acceptance
  - D- Using placebos, with informed consent ahead of time, to assess effectiveness in the school setting

Question 5

- In adult and child studies, adherence to medication depends on all of the following EXCEPT:
  - A- The transference and countertransference relationships with the prescriber
  - B- The working relationship with the pharmacist
  - C- Ease of use
  - D- Side effects
  - E- The "relationship" that the patient carries on with the pills themselves

Introduction and Overview

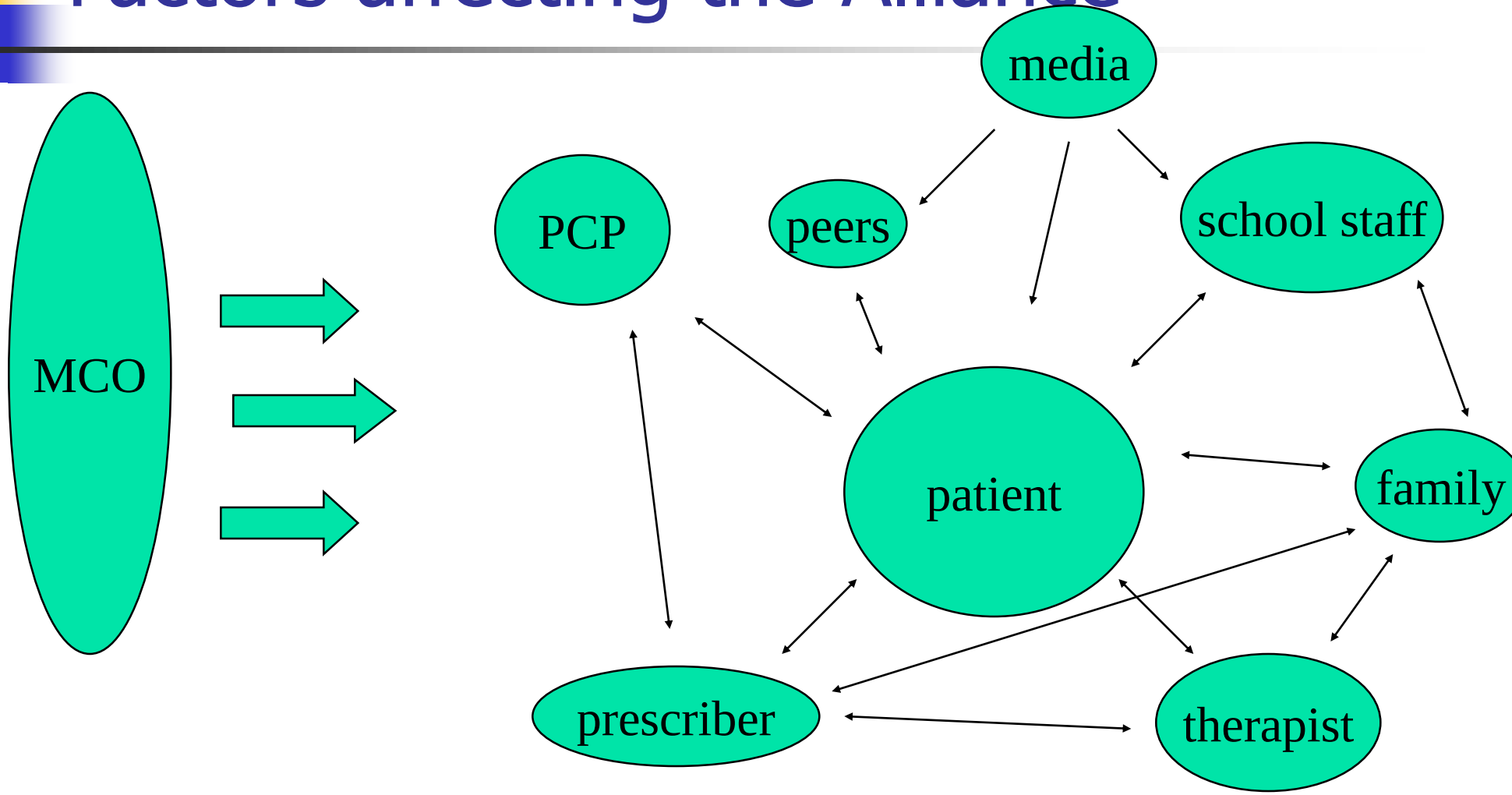
- The role of the therapeutic alliance in psychiatry
- The psychological implications of administering medications
- Specific developmental issues to be acknowledged when working with children and adolescents
- The role of the dual alliance (with both patients and parents) for practitioners of psychopharmacology in 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



Adapted from Carli, 1999

Rationale and Theory for studying the Alliance

- We must be able to retain our abilities as *therapists* in all that we do
- 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)

Definition of Working Alliance

- Common to all forms of psychotherapeutic intervention, a strong working alliance has at its core the concept of *mutual collaboration against* the common foe of the patient's presenting problem(s). It integrates both the *relational* and *technical* aspects of treatment.
  - *Cf.* "Helping Alliance"

Rationale and Theory for studying 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
  - 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 *bond* 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!
- The offer of treatment as a non-neutral act
- “Prescription” as a misnomer

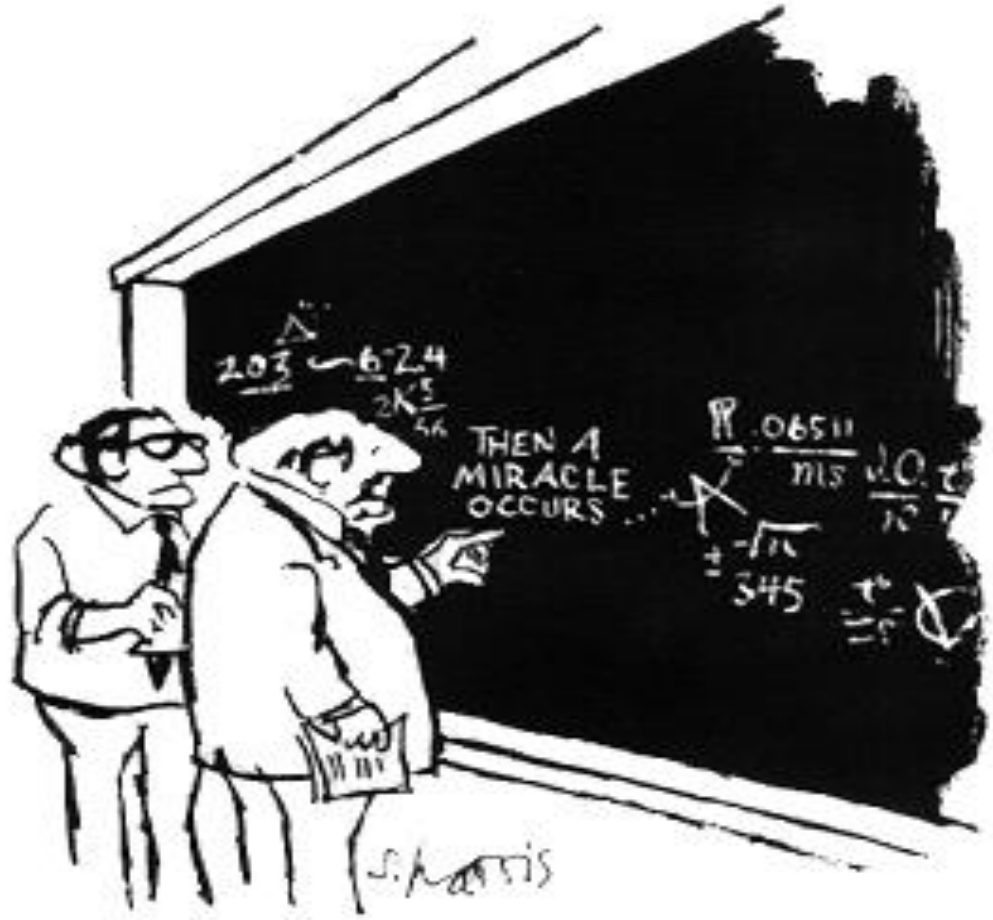
Rationale and theory for importance of this approach

- 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; ABPN 2007)
  - 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



"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

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

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.*"

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": <u>normalizes the reality that families have variable responses to stressors in their lives.</u>

Empiric Support

- DeChillo, et al (1994)
  - Pro-active vs. Less pro-active sense
    - An often necessary, more pro-active stance may be a struggle for trainees with a more psychodynamic approach/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 possesses 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

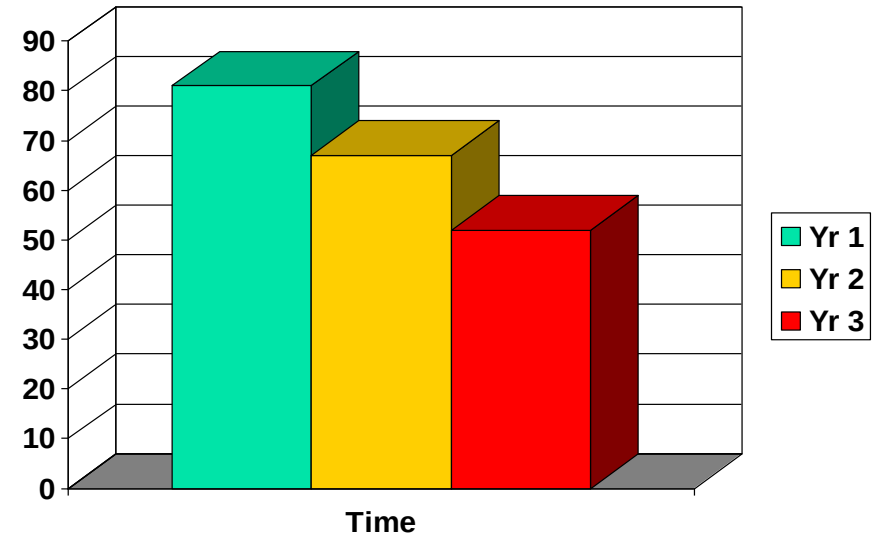
- Kazdin, et al (1997):
  - a poor alliance was one of the factors predictive of treatment dropout within families of children with externalizing symptoms on the oppositional-defiant-antisocial continuum

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:
    - 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

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 Psych***, 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

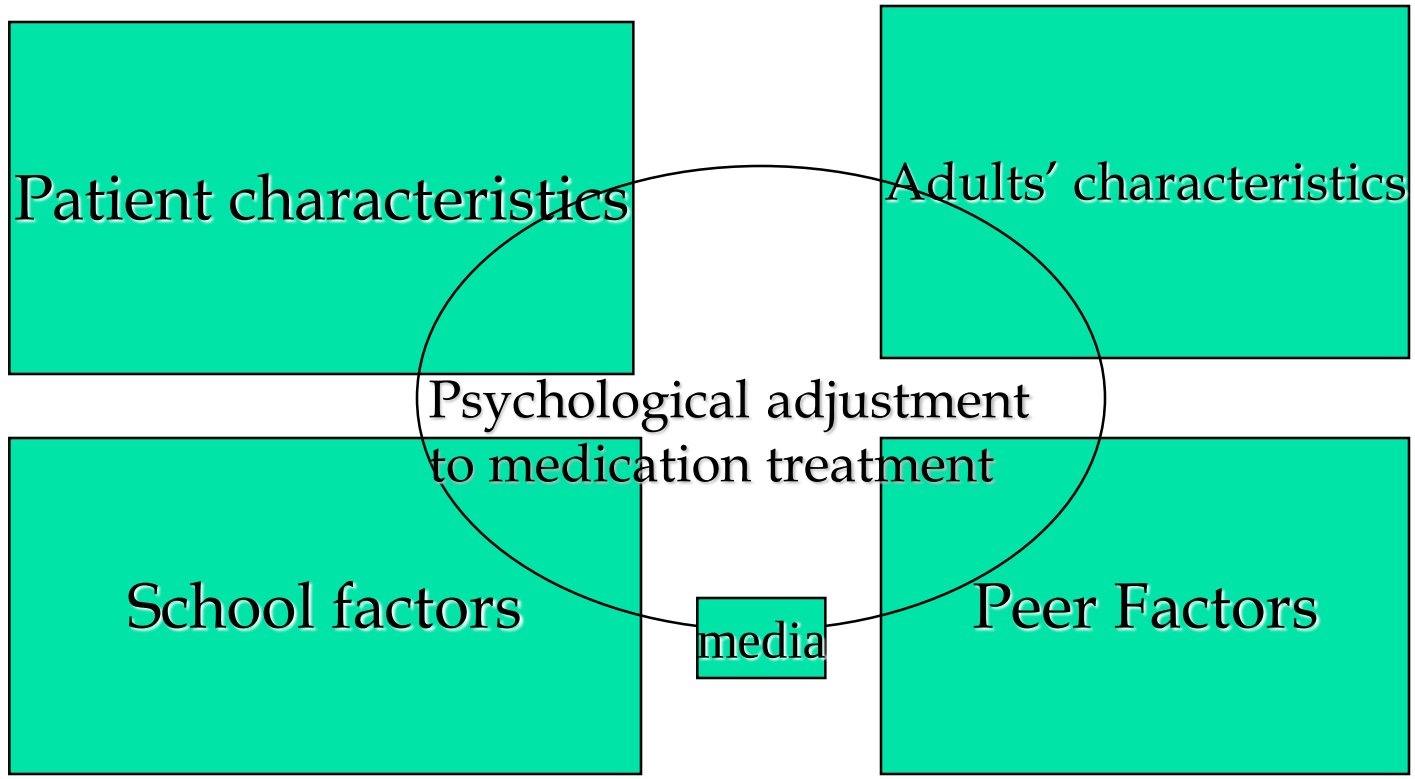
- NIMH-TDCRP study, cont'd:
  - Results: Therapeutic alliance had significant positive effects on clinical outcomes for both psychotherapies and pharmacotherapies
    - Med group results (IMI+cm, PBO+cm) : Alliance alone may have strongly influenced the placebo response.

NIMH-TDCRP study, cont'd:

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

-Krupnick, et al.(1996)

Factors affecting adjustment to medication treatment



Mechanism of Effect

- Patient characteristics

  -Internal working model of receiving help and support

  -Attachment status

  -Age of child / teen

  -Past outcomes

  -Relationships with MD's, teachers, counselors

  -Transference influences ability for alliance formation

Mechanism of effect

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

Mechanism of effect

- School and peer factors
  - Teachers and nonverbal cues
  - Pediatric patients and connection to a peer or famous person with a similar problem

Mechanism of Effect

- School and peer factors
  - Teens' feeling "different"
    - Damaged goods dynamic
    - Prescriber
      - agent of their parents, or ally of the teen?
- Media factors
  - Internet, music videos, television, print media

Integrated Treatment

- Defined as the combined use of psychoactive medication and psychotherapy (Pruett & Martin, 2003; Schowalter, 1989; Steiner, et al. 2004))
- Components
  - 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
  - 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 directed primarily to them
    - Other option—"Who shall I give this to?"

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”

Table 1: Children's concepts about medication

Physical properties of the medication itself:

- **<u>Name of the medicine</u>: May help to enhance or decrease adherence, depending on association**

- **<u>Form:</u> liquid, tablet, capsule or injectable form may each carry specific and different meanings**

- **<u>Size:</u> the bigger the pill or mg size, the bigger the problem (and vice versa)**

- **<u>Labeling & printing:</u> personalized associations tend to be made with imprinted numbers or letters**

Adapted from Pruett & Martin, 2003

Table 1, continued

The need to take medicine:

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

Timing of the dose:

<u>Frequency:</u> greater frequency may be seen as more trouble, or perhaps, more help

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

<u>During school:</u> concern about stigma

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

Pruett & Martin, 2003

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, *JAACAP* 1989; *p.683*

The meaning of the medication itself, and on the self

- BRAND
  - Prescriber as billboard: Drug companies spent $13,000 (2005) in direct marketing of "brand" to physicians, in the hope that they will use / display all pens, cups, notepads, and convention bags/briefcases regularly.
    - Ample data show that drug product detailing /industry contacts with MDs change prescribing practice (even after a single contact)
      Zipkin and Steinman (2005), *Jnl Gen Int Med* 20(8); 777-786
    - 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
  - Others worry that self perceptions will be altered

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

    (Pruett & Martin, 2003; p.418)

Avoiding "backhanded" compliments: those that ascribe children's improvements in behavior primarily to the medication, over the child's efforts ---MD should educate parents & teachers about this

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

Countertransference Issues in Pediatric Pharmacotherapy

-Prescribing in order to medicate a difficult patient into docility, or to silence an annoying family who pressures you to treat their child

-Prescribing to maintain an alliance with a 3rd party (caretaker, school, group home, court)

-Prescribing to "try out" a medication prior to graduating

-Changing from Integrated Treatment to Split Treatment in order to avoid seeing a difficult family more than once per month

-Not prescribing (or prescribing) in order to "prove a point" to the therapist or case manager

Medication Adherence

- In adult and child studies, adherence to medication depends on :
  - The working relationship with the prescriber
  - The transference and countertransference 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)

Medication Adherence in Pediatrics

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

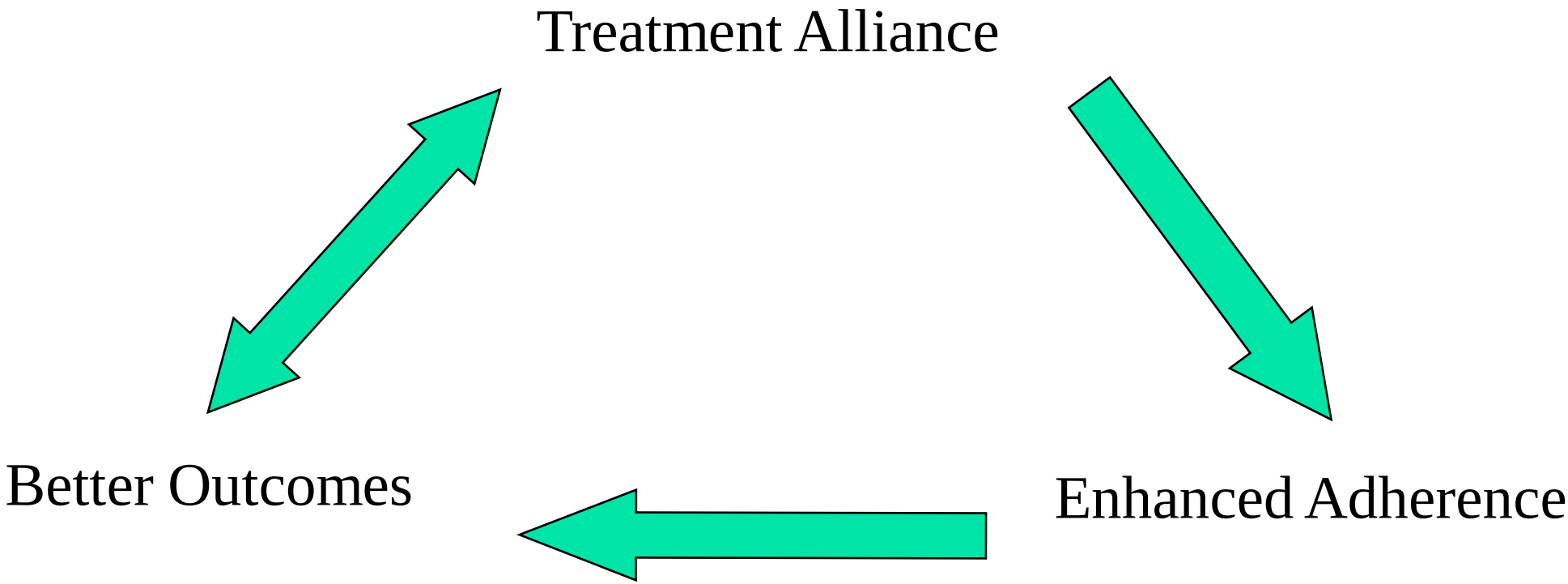
Stanford Specialty Clinic experiences

- 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)
  - Faculty, Trainees and Staff actively solicit opinions and get information from parents regarding 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



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)

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 to see if this child needed medication
- 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 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
- Will help to create evidence-based guidelines for training directors in psychiatry to model and teach the practice of integrated treatment

Conclusions

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

Blackwell, 1973, *p.252*

Guidelines

- 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

Guidelines

- 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.

Guidelines

- The case formulation should be the prerequisite to the prescription, and not vice versa
- 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?)

Guidelines

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

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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Answers

- 1-a
- 2-c
- 3-a
- 4-d
- 5-b

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