Psychotherapeutic Strategies to Enhance Medication Adherence

September 29, 2017 | Special Reports [1], Psychopharmacology [2], Psychotherapy [3]

The authors outline a series of strategies that can help promote adherence to the therapeutic regimen.

Treatment nonadherence in psychiatric patients contributes to increased suicide rates, illness exacerbation, hospitalization, and mortality. Nonadherence affects family relationships and society as a whole by both direct costs and loss of productivity. Most experienced clinicians do not need data to convince them of the widespread nature of this problem, but some recent work illustrates how pervasive it is.

Findings indicate nonadherence rates of 40% to 60% for antipsychotics, 30% to 97% for antidepressants, and 18% to 56% for mood stabilizers.\(^1\)\(^-\)\(^4\) Julius and colleagues\(^5\) examined the rate of medication nonadherence based on diagnosis. The rate of nonadherence was 28% to 52% for MDD, 20% to 50% for bipolar disorder, 20% to 72% for schizophrenia, and 57% for anxiety disorder. An inpatient cross-sectional study showed that the rate of nonadherence was 45.5% for bipolar disorder, 12.1% for schizophrenia/schizoaffective disorder, 18.2% for depression, and 24.2% in other disorders.\(^6\)

Patient outcomes may be improved by systematically targeting adherence in all patients who are given psychotropic medication; the **Table** provides suggested strategies for promoting adherence. The following summarizes some of the recent work in cognitive behavioral therapy (CBT) that indicates it may be helpful in severe and persistent mental illnesses.

**Adjuvant cognitive-behavioral therapies**

CBT for bipolar disorder can enhance treatment adherence and improve overall treatment outcome. Cochran\(^7\) obtained significant improvement in adherence in outpatients with bipolar disorder by applying CBT strategies to enhance knowledge about treatment and to change attitudes toward treatment. Another CBT study in bipolar disorder showed decreased relapse rates with increased medication adherence.\(^8\) Randomly assigned patients with bipolar disorder and comorbid substance use disorders—a particularly difficult group to manage—received 12 weeks of low-intensity medication monitoring alone or in combination with CBT. The CBT group showed improved medication adherence on a compound measure derived from both patient self-report and blood levels of mood stabilizers.\(^9\)

In patients with schizophrenia, a number of studies have increased adherence to psychotropic medication by employing motivational interviewing and CBT. Gray and associates\(^10\) reported that CBT has significant effects not only on medication adherence but in improved attitudes of patients toward treatment. Cavezza and colleagues\(^11\) found significant effects of CBT interventions in psychotic illness on both medication adherence and improved psychiatric symptoms at 3-month follow-up.

All clinicians can employ principles of CBT in their work with patients. Even in brief medication management sessions, elements of CBT can be tailored to the needs of the patient to enhance outcomes.

**CASE VIGNETTE**

John is a 22-year-old senior in college. He has been stable on medication for bipolar disorder since his last year in high school. He has a good treatment relationship with his psychiatrist, but in the past 6 months John has had more difficulty with keeping appointments and far more variability in lithium blood levels. He has a very busy class schedule; he is applying to graduate school and plays varsity basketball.

**Challenges to taking medication**

For many patients, taking medication can be a challenge. Patients more easily discuss difficulty with adherence when clinicians are transparent about how universal the problem is. Judicious use of self-disclosure may help to make it safe enough for the patient to tell you the truth. If you are
comfortable, let the patient know about your own problems with adherence. Most people have found an antibiotic capsule or two in the bottle at the end of a course of treatment.

Cultivating a warm and empathic therapeutic alliance is critical to collaborating about concerns that could upend the plan to take medication. In addition, the plan must be modified when life circumstances change and present new obstacles. Travel, moving, or loss of family support can affect the patient’s typical reminders or motivation to stay on track.

A defining feature of most psychotherapeutic approaches is to individualize treatment based on a specific case formulation. Conceptualizing the patient’s difficulty with taking medication helps us to better manage complexity and tailor interventions accordingly. In a CBT model, we must understand what meaning the diagnosis, symptoms, and treatment have for the patient, in the form of thoughts and beliefs. If a patient thinks taking medication is a sign of weakness, for example, this thought will have a powerful effect on adherence.

Understanding the patient’s values and central concerns and linking these to the benefits of medication treatment is an excellent strategy to facilitate adherence. For example, if sleep is a problem, a good motivator for a patient to take nightly medication would be if it induces sleep. However, when sleep improves, the patient may be less likely to take medication as directed without using other prompts.

The formulation should identify aspects of the patient’s daily life that may interfere with the behavior of taking medication. Diagnostic characteristics of an illness such as hopelessness and memory problems can inherently produce problems. Trust issues, commonly seen in personality disorders, are another significant impediment. Stressors—whether from co-occurring medical problems, finances, or interpersonal relationships—will worsen adherence. Some patients have never cultivated or have significant impediments to routine; living in a shelter, for example, is hardly conducive to adherence.

CASE VIGNETTE CONT’D
As John’s stressors increase, his self-care becomes less of a priority and his routines are less predictable. His psychiatrist addresses the variation in his blood levels and normalizes the struggle with taking medication during times of stress and unpredictable schedules. The psychiatrist self-discloses that when traveling, she finds it difficult to remain on schedule with her blood pressure medication. This makes it easier for John to speak about the fact that remembering the pills just “feels like too much” and that the adverse effect of tremors is interfering with his free-throw shooting.

Promoting desired behaviors
Very frequently our discussions with patients emphasize the adverse effects they are experiencing, particularly after symptomatic improvement. The practice of asking “Are you taking your medication?” followed by “How are the adverse effects?” will be less effective at obtaining accurate information—and will remind the patient that dry mouth, anorgasmia, and sedation are the result of taking medication. Emphasize the positive effects of the medication to counterbalance the adverse effects.

It is normal to forget much of what is said during a physician visit, so written information must accompany medication discussions. Teach patients to take notes and to write down questions between sessions to make them better partners. Genuine interest in the patient’s point of view enhances all aspects of the therapeutic alliance and, subsequently, adherence. Internet searches are commonly used for medication queries, not all of which produce positive results. Guide patients to reliable sites to help them be informed consumers. Bad information may be more harmful to adherence than no information at all!

Behavioral techniques are essential for forming habits, and taking medication regularly invariably involves habit change. Such techniques include self-monitoring (eg, charting medication taken each day) or reminder systems (eg, a pillbox, pairing medication doses with routine activities). Some less commonly used effective behavioral strategies include adding positive reinforcement (such as reading a favorite magazine) after several days of taking medication correctly.

Behavioral experiments can enhance the likelihood that patients will try a particular medication. For example, the patient may take a medication for the first time and spend the day in your waiting room when concerned about possible adverse effects of the drug.

Cognitive techniques are helpful when the patient’s thoughts about medication are a barrier to adherence. CBT interventions can be quite effective in developing alternative ideas about medication. A patient can use a decision matrix to list the pros and cons about a medication. This
may be useful when the patient is unsure about pharmacotherapy. Evaluating negative thoughts about medications, psychiatric illnesses, or physicians may facilitate the willingness to take medication, or to take it more regularly. Education, managing stigma and shame, and correcting misconceptions about health care providers may be subjected to behavioral experiments and evidence gathering. A basic CBT premise is not to tell the patient what to think, but to help the patient consider thoughts as testable hypotheses. For example, to help a patient develop more accurate ways of thinking about medications, ask him to consider what he would say if his child, spouse, or best friend required such medication. More global beliefs about the motives and trustworthiness of others may need special attention and efforts to build a trusting relationship with the patient over time. Empathic, validating comments, and open and direct communication about how difficult trust is may facilitate better adherence.

CASE VIGNETTE CONT’D
John and his psychiatrist discuss very specifically which days are most difficult for him regarding taking his medication. John has always used a pill box with the days of the week to help him stay on track. He noticed that Friday and Saturday were the most frequent days he missed taking the medication—John’s games were scheduled on these nights. The psychiatrist and John agree to a plan that aggressively targets his tremor, which results in improved adherence.

SIGNIFICANCE FOR THE PRACTICING PSYCHIATRIST

TABLE Strategies to enhance medication adherence

Disclosures:
Dr. Sudak is Professor, Director of Psychotherapy Training, Senior Associate Training Director Department of Psychiatry, Drexel University, Philadelphia, PA; Dr. Ayub is Resident Physician, Department of Psychiatry, Drexel University.

The authors report no conflicts of interest concerning the subject matter of this article.

References:


Source URL:
http://www.psychiatrictimes.com/psychotherapeutic-strategies-enhance-medication-adherence

Links: