Outline—Brief Treatment

History of the problem

1. Open ended questions regarding the problem including establishing the patient's and families' view of the problem.
2. Sequences of events surrounding the problem including interaction with significant others. A description of the problem in the context of a typical day.
3. Attempted solutions by patient and others trying to help.
4. When is the problem even slightly better?

Goal setting

1. Ask—What would be the first sign that a small improvement would have occurred? (e.g. miracle question—If you woke up in the morning and your problem was better, how would you know it?)
2. Analyze—What needs did the activities surrounding the problem satisfy? (life stages)
3. Analyze—What has changed to make this a problem now?

Treatment

1. Reframing: viewing the problem differently leading to different behavior.
2. Altering sequences surrounding the problem.
3. Motivating the patient and significant others to make useful changes.

Protocols for common problems

1. Self-observational task.
   a. Indications-patient defines the problem as outside their control (e.g. panic disorder, bulimia)
   b. Plan-the patient is told to keep a detailed diary of symptoms, thoughts and interaction with others from preceding symptoms through resolution of the symptoms.
2. Solution focused task
   a. Indications-patients are motivated to try something new but could become resistant to change. This intervention helps avoid resistance to change.
   b. Plan-Disallow discussion of blame for the problem. Get a detailed description of when the problem is slightly better. Develop a plan with the patient and if possible with significant other to recreate the times of improvement more frequently even if it is only slight improvement.
3. "As if" task.
   a. Indications-to interrupt repeating behavior patterns and habits that lead to needs getting met in problematic ways. (e.g. frequent relapse from chronic pain treatments)
   b. Plan-Request the family and patient "act" as though they do not have the problem for a negotiated period (e.g. one hour) or to prevent relapse act as though the problem has returned for a period (e.g. one hour) to practice their response.
4. Restraining directives

a. Indications-highly resistant patients.
b. Prescribe the patient have the symptom or resist treatments. Give the patient a very respectable but slightly uncomfortable explanation for this plan.

AN APPROACH TO BRIEF TREATMENT IN FAMILY PRACTICE

Introduction

It is well known that psychosocial problems in family practice are common. In the past, however, many family physicians have been frustrated by the difficulties in fitting effective treatments into the family practice setting. Treatments commonly used by therapists and psychiatrists, although highly effective, are often not practical for the family physician. This chapter lays the foundation for an overall approach to the patient with psychosocial problems. The family physicians use of brief therapy, psychoactive medication and referral will be discussed. More specific discussion of treatments for specific problems follows in other chapters.

Over the past ten years there has been a growing degree of activity in developing brief therapeutic interventions, which fit into the family practice setting. They are particularly useful for the most common problems seen by the family physician, such as adjustment disorders, depression, anxiety, somatoform disorders and child behavioral problems. Certainly these therapeutic practices will not solve all the problems which patients bring to the physician. Referral and consultation will still be necessary for some; however, it will solve many of the most common problems. Thus, the family physician can address most of the common psychosocial problems just as they do in other areas of medicine. Furthermore, when the physician makes a counseling attempt even if it is not fully successful, the patient is then more open to a referral.

The improved effectiveness of brief therapy has been made possible by a shift in the way therapists approach treatment strategies. In the first half of this century psychotherapy was based on the concept that if one could come to understand how their problems developed in their past history, this understanding would lead to health promoting change. However, research proved this insight oriented approach was not effective for many people. At the same time a different view of problem solving was developed. This view is based on studying how people change, spending little energy focusing on how their problems develop. Most of the therapies which have recently been found to be most effective in helping people change are based on three processes: reframing, resequencing, and restructuring.

Some approaches to therapy attempt to change all three, however, it has been found that even changing one of the three often leads to significant therapeutic benefit. One approach, reframing, helps people change the way they think about their problem. For example, many people with anxiety disorders come to their doctor believing that the best way to deal with their fears is by avoiding them in any way possible. If they come to understand that the more useful way to approach the problem is gradually approaching their fear in a step-wise fashion, the problems are likely to remit.

A resequencing helps people change by altering the sequence of events surrounding the problem in a strategic way that leads to a different outcome. For example, some parents after their child disobeys, confront this by making a greater and greater attempt to explain to the child why they should do the requested behavior. The more they explain, the more stubborn the child becomes. Often when the parents are taught to ignore the child's poor behavior totally and then pay a lot of attention to the child when they are behaving appropriately, this altered sequence of events leads to improvement.

Restructuring is aimed at changing the structure within a family. The most common example of this is a child with behavioral problems whose parents are attempting to be their friend rather than their authority figure. Changing the structure from a peer relationship to parent as authority figure is often helpful.

In summary, altering the way people think about their problem, the sequence of events surrounding the problems, and altering the family structure will often lead to helpful change.

Although achieving these goals at first blush may sound simple, the experienced clinician knows otherwise. People tend to avoid change even when knowing it might be useful. Homeostasis, that is stability, is a very powerful force. Some even define psychotherapy as nothing more than overcoming resistance to change. The process of brief therapy as will be discussed is based on using approaches that avoid resistance as much as possible or where not possible to avoid, use resistance as a strategic motivator for change.

There are, however, certain approaches which doctors sometimes take which handicap their ability to promote change. One handicapping belief is that people who have problems are motivated to change and come to the physician for help with change. In fact, most who come to the physician's office are in some sort of discomfort and they want the discomfort to stop. Far from desiring to change, they want the physician to simply cure them so that they no longer have the discomfort, be it physical or psychological. Therefore, the physician's role is frequently to motivate the patient to change.

Another handicap is the belief that you must know the diagnosis and etiology of a problem in order to treat it. Physicians commonly treat disorders without knowing the exact etiology. In fact, an over enthusiastic pursuit of a definitive diagnosis often causes more problems than it solves. For example, the physician who feels as though they must absolutely know the cause of a chronic pain will pursue diagnostic studies often with no definitive results and the problem worsens. When the dangerous etiologies have been ruled out, it is often better just to pursue treatment even if the exact definitive diagnosis is elusive.

Another belief that can handicap change is the belief that people need to feel better in order to be motivated to change. In fact, quite the opposite is true.

People are motivated to change because they are in discomfort, when they feel better they are more complacent and willing to leave things as they are. Often times the belief that people must feel better too quickly moves the physician to use medications that cover up a problem temporarily without really developing a lasting resolution.

Another handicap is the belief that patients know and directly communicate their problem. Very often the patients know the pain, but not exactly the problem. It takes a good history to define what the problem really is. For example, a patient comes in complaining of depression without apparent cause. A description of the problem soon reveals that their relationship with their spouse has become more and more distant and hollow over the last year and they are in fact grieving the loss of this relationship. Patients, when they are distressed, often focus on trying to figure out who is to blame for their problems rather than on solutions. They focus on historical explanations and since one cannot change their past this promotes the idea that making meaningful change is impossible. It is therefore useful to avoid issues related to blame or historical explanation.

Another way to fail is to focus on a problem different from the patient's. A typical example of this, is the physician who confronts a patient with somatoform disorder, telling them it's a psychological problem not a physical one. It is much more helpful to use the patient's view of their pathology as an explanation to facilitate useful change. For example, your pain is quite distressing and from the sounds of things it is really ruining your lifestyle. There are some things we can do to help you regain control over your life and not let the pain ruin it. This explanation avoids whether or not the pain is physiological but focuses on functional status as something that is treatable using behavioral techniques.

Another mistake commonly made is to neglect to find out what solutions have already been attempted to resolve the problem. The physician then makes a suggestion to repeat a solution that has already failed. If the patient is to be motivated to make a change they must feel that there is something different about this solution from one which has failed in the past.

Finally, it is important not to get ahead or work harder than the patient or family. For example, doctors can enthusiastically make recommendations for lifestyle change such as exercise programs where the patient is not yet convinced or ready to even attempt these activities. This is liable to lead to a "yes, but" set which will make motivating the patient for acceptable change even more difficult. The physician in this case must slow down and continue the search for motivating goals or acceptable activities.

The Brief Therapy Process

While the examination procedure which the family physician follows for a brief therapy interview is similar to that followed for a more general examination, there

are some differences which help guide the process efficiently to the three change processes previously discussed, that is reframing, resequencing, and restructuring. It is useful to organize the interview into four steps: 1) exploring the problem, 2) exploring attempted solutions, 3) exploring visions of improvement (goals), and 4) delivering the intervention. The intervention should include an assessment or explanation of the problem, which motivates and specific activities, which will alter the course of the problem.

As with all medical interviews, the brief therapy interview starts out with exploring the problem. Initially, just as with any other history taking, the physician should begin with open-ended questions aimed at establishing the patient's and their family's view of the problem. It is important to get this in a broader perspective than simply asking for specific symptoms. If a patient says I'm here because I'm depressed the physician might ask how is your day different when you are depressed from when you are not depressed? How does your family see you as being different? It is then important to understand the sequence of events that surround the problem, including specific action and dialogue which occur because the person has the problem. For example, what is different about how you spend your day because you are depressed, than how you would spend your day if you weren't depressed? How do people treat you differently because you are depressed, particularly your family and significant others? Finally, in understanding the problem it is helpful to identify when the problem is even slightly better. If you notice when your mood lifts even a little bit, what is going on in your thinking and in your environment when things are even slightly improved?

When a detailed understanding of the problem is complete, the next step is to obtain a history of attempted solutions both on the part of the patient and the significant others. There are two good reasons for understanding attempted solutions. First, attempted solutions that have failed are now part of the problem. That is, they are part of the sequence of events, which maintains things as they are. Even if they make sense, since they have not yet succeeded in making things better they must be altered in some way to allow a different result to occur. How have you tried to help yourself out of your depression? How have others tried to help you out?

Goals of treatment should be the next topic. A good way to ask about goals is to ask the patient and family to imagine what would be the first sign that a small improvement had occurred. Another way to ask is called the miracle question, if you woke up in the morning and miraculously your problem was better, how would you know it was better? Again, dialogue and action sequences should be part of the description since this is the raw material of therapy that can be altered to create change.

Once a physician has an understanding of the goals of treatment, one is ready to turn to treatment planning. It is important for goals to be measurable and

realistic. For example, I want to be happy is not measurable. The doctor should respond to this statement with what will be different about your day in how you think and how you interact and do things differently when you are happy? This is measurable.

In addition to the information already acquired, it is useful for the physician to analyze the whole of the information, thinking about what needs are being met by the problem. This is best conceptualized in terms of life context. For example, if a teenager is acting badly, getting into trouble, one might consider the possibility that the goal of this activity is rebelliousness towards parents and thus gaining a sense of independence. In order for the teenager to give up the problem behavior, other behaviors which will satisfy the need to gain a sense of greater independence from parents will need to be replaced or there will be a great deal of resistance to any change and it will not last long term. This is especially important when addictions are involved. What needs has the addiction filled and what other means of meeting those needs might be considered in the treatment plan?

Another important factor to be analyzed before a treatment plan is developed is why is the problem being brought to the doctor at this particular time. For example, if someone complains that they have been depressed for 15 years, but just presented this to the physician, one should consider that something has changed to make this a higher priority than in the past.

Assessing the Problem and Treatment Planning

Assessment for a brief therapy intervention requires more complexity then a DSM- IV diagnostic category. It is useful to begin by analyzing the following issues. 1) In the patient's view, what is the problem they are motivated to work on; what must change for the patient to see the problem as resolving? 2) What needs is the present pattern of behavior satisfying? What can the physician foresee as possible options for getting these needs addressed in a less problematic way? Why is the patient likely to resist change? What is likely to motivate them to be willing to make changes that may initially be uncomfortable? 3) What is easiest to change about how the patient thinks about the problem or acts on the problem which is likely to lead to resolution? 4) How are significant others contributing to the status quo?

To be effective the plan usually must include a specific directive or assigned task based upon the above analysis of the problem with the goal of the patient and often their significant other changing the way they usually do things. The directive should include a specific set of actions that will alter the sequence of events or the thinking process surrounding the events. Usually the directive is given in a way that motivates the patient to follow the specific instructions. Sometimes in highly resistant patients, however, a directive is given in such a way that increases the patient’s likelihood of rebelling against the directive. In this case, the goal is to get the patient to change by rebelling. It is usually best to

start by requesting small changes to assess how much resistance there may be. Following this, based on feedback received, increase the expectation to change until the problem is resolved.

For the patient who is uncomfortable because of a problem, motivated to change, and demonstrates little resistance, a straightforward explanation will often be effective. This includes a new explanation that the patient accepts and a plan that follows from the new explanation that the Doctors expect the patient will follow. For example a physician sees a six-year-old a number of times for different somatic complaints which the doctor recognizes as related to missing school. The parents even bring this up with the child but dismisses it initially because the child repeatedly says there's nothing wrong at school. After the examination, the doctor tells the parents that the child may be avoiding leaving home or daycare where they are use to things rather than facing the novelty of a new school. The parents must teach the child that feeling sick is not a reason to avoid school. The parents follow through and soon the child's symptoms improve. Family physicians commonly treat children with separation anxiety in this way. A new explanation for a problem and a specific directive to alter the problematic sequence often works and is usually the first line treatment approach taken for this and most other problems seen in family practice. When however the patient does not respond to this approach, alternative interventions may get better results. Below are four alternative treatment interventions in order of increasing complexity.

The four protocols described here are 1) the self-observational task; 2) solution focused treatment, that is, doing more of what works; 3) the as if behavioral approach, and 4) restraining directives.

Self-observational Task

The self-observational task can be used for a whole host of problems but works particularly well when the patient defines the problem as outside of their control. This task can help the patients experience ways the problem can be brought under their control. Examples of problems that often respond to self-observational tasks are panic disorders, bulimic disorder, certain depressive disorders, some impulse control disorders, and circumstances when parents feel they cannot control their children.

The physician introduces this by requesting that the patient and the family member, if present, initially not try to change anything but to gather more information. The patient and sometimes significant others are asked to keep a detailed diary of the symptoms. This diary should include the day and time the symptoms occur, the sequence of events leading up and following the commencement of symptoms including the thoughts and dialogue with others that occurred. They should include anything that led to improvement or worsening of the symptoms. Finally, they should describe how the symptoms resolved. The patient and family member are requested to write this as soon as

possible after the symptoms have begun or at least immediately after their resolution in order to assure the best accuracy.

Another variation on this protocol is for patients who tend to dwell on their symptoms involves asking them to keep a diary of any times when their symptoms seemed to be even slightly improved. This is particularly useful for depressed patients or patients with generalized anxiety. Other aspects of the diary are the same.

In order to motivate the patient and family to perform the task, the doctor can explain that their problem is complicated and a more detailed understanding would be helpful before any attempts to change are undertaken. For patients with panic disorder, for example, it helps to explain that the first step in helping them gain control over their problem is getting a very detailed account of the problem.

The outcome of this intervention is often a significant attenuation of the symptom very soon after they start implementing this plan. This likely occurs because the self-observational task gives them a feeling of being more in control almost immediately. Since many symptoms such as bulimia and panic disorder occur when a patient feels out of control, this prompts an almost immediate positive improvement. It is usually not helpful to explain this to the patient. The explanation trying to gather more information is usually sufficient for the patient.

Follow-up about one week later is recommended. If the patient has improved sufficiently, they can be told that simply by learning more about the problem they are gaining better control over it and therefore do more of the same. Another option to further self-control is for the patient to attempt to bring on the symptom at a prescribed time, then use a relaxation exercise to control it. This leads to a greater sense of control. They should keep a diary in the same way. This further leads to an increase in self-control since the very act of attempting to bring on the symptoms puts one in charge of the symptoms.

Family members can be asked to observe this process and keep their own diary as a way to understand more. Getting the family members to observe without getting involved in providing reassurance to the patient helps alter the sequence of events in a direction, which further allows the patient to feel more in control. If the self-observational task works then follow-up visits can mainly consist of requesting that the patient do more of the same until they are feeling like they have good control over the problem. If the problem persists, another of the approaches that follows can be tried.

Solution Focused Approach

A solution-focused approach is another type of directive, which can be used for a wide variety of problems. It is based on the observation that many people are less resistant to change when change is viewed as nothing more than an

extension of what they are already doing. Since a great deal of resistance to change comes from feeling at fault [guilty] for the problems or from fear of the unknown, doing more of what works avoids this resistance. A solution-focused approach is especially useful as an initial approach for patients who have a significant potential for resistance to change. For example, family members may be blaming each other for the problem and therefore feel that agreeing to change means admitting the problem is their fault.

As the solution focused approach is built around the concept of doing more of what is already working; it is important to gather a very detailed description of the circumstances in which the problem is better, even slightly better. For example, the patient might be asked, "although you are very depressed, even those who are depressed have times during their day or week when they feel a little better. I'd be interested in a description of when you feel even a little better." The description should include at least one specific time when the patient felt better. It should include specific dialogue and actions which preceded the better time and what followed afterwards. The doctor should understand what the patient believes made this event an exception to the rule, however small.

In doing an assessment of the problem the physician should ask himself/herself what is different about the times that thing go better. Are needs being addressed in a different way during these times? Are negative interactions being avoided? The purpose of evaluating these issues is not to provide insight to the patient, but to strategically recommend activities to the patient and significant others which will expand and increase in frequency these positive experiences. In fact, usually it is best to not offer much explanation for solution focused directives beyond, "that is what has worked in the past for you, let's figure out a way to do more of it."

For example, a well educated mother of a 4-year-old boy at the end of a pre-school physical examination reports that her son throws horrible tantrums before he goes to bed at night. These have become worse lately, and in fact have become quite frightening to both parents since he has screamed that he'd rather die than go to bed. This usually leads to the parents sitting down with the boy and asking him what is wrong. These discussions can last an hour. In the morning they report he is always fine until the next night. When asked if there is ever a time when things seem to go better, the mother reports the one night she and her husband were going out together at the child's bedtime. The child threw a similar tantrum when they were leaving. Since they had to meet another couple, they told the child that they had to go and immediately left. The baby-sitter reported after they left the child stopped crying and went to bed without trouble. The mother suggested that perhaps it was their fault the child was troubled. The doctor stated fault was not the issue but that they had learned on this one occasion a way that seemed to work, that is simply not respond to his tantrum and leave the room. They were warned that his behavior could get worse for a few nights. A week later the mother called back to report the child

had only had one bad night and since had been going to bed quite easily. The doctor in this case could have spent a lot of time on the child's separation fears. The doctor could have focused on the parent's need to be overprotective, or the child's need to manipulate for attention. However, by focusing simply on what had worked to improve the problem and expanding it to a regular routine, the child got better.

As If Interventions

The as if interventions are slightly more complicated to introduce, but are effective for a wide variety of habit disorders and relapse prevention for a host of problems. For example, psychosomatic disorders commonly improve briefly no matter what the treatment, but then the patient relapses because of a large secondary gain component. The as if directive can be used to prevent relapse once a behavior has improved and needs are now being met in a new way. It can also be useful in circumstances when people's resistance to change is related to fear of trying something new. It might be a way for a couple to experiment with different ways of altering a sequence of events in a problematic relationship, such as a codependent relationship or a jealous relationship. It is often helpful to start the plan with a challenge such as, "I'm not sure your ready for this change" or "it might be helpful to see what a change might be like before really committing to it", or "let's experiment with some changes to see if they work for you."

The as if behavior can be presented in two different ways. The identified patient and family can be asked to act as if they are normal. That is, they act as though they do not have the problem for a negotiated period of time. For example, act as if you don't have pain for one half-hour three times a day and the family should act as though you don't have the pain as well. The second way of requesting the as if behavior is primarily for prevention of relapse once a positive behavior has been attained. In this case the patient and family are asked to act as if they do have the problem for a specified period of time. For example, they might be asked to act as though they do have the pain for two hours a day so that the family can practice distracting techniques for when the real problem might occur again.

There are a number of different approaches that can be used for motivating families to use the as if process. One can challenge the family's readiness for facing a difficult behavioral problem. When requesting that the family practice normal behavior for a brief period of time another approach is to suggest doing this to explore what it would be like to be normal. For example, a couple who continually battle over jealousy might be asked to act for two hours, two evenings a week as though they are not jealous of each other to explore what their relationship would be like if they didn't have this problem. Another approach is to appeal to a family's and patient's curiosity. For example, the doctor suggests that they practice normal behavior for a specified period of time to experiment with different alternatives to approaching the problem. This might be combined

with the self-observational task in requesting that they write down the results of these different as if periods.

The outcome from using as if directives is often patients and significant others try new behavioral interactions that they otherwise would not. This leads to a lessening in their rigidity and resistance to change. For example the family who only gives each other attention when someone is sick, learns to give attention when the patient is healthy leading to a lessening in somatoform behavior. The child who throws tantrums for attention from a parent afraid of ignoring this behavior for fear of being rejected by the child learns to get attention in a new way. A family which is afraid to not rescue a family member from an anxiety attack learns that this member can tolerate some anxiety at least for a short period of time, which can grow into longer periods. New behaviors which have been resisted out of fear are tried in a safer environment under the as if directives.

Restraining Directives

This type of intervention is used for non-compliant patients or those highly resistant to making changes necessary to resolve their problem. This technique is often used when other attempts at therapy have been tried, but failed because the patient did not do the requested tasks. It is especially useful when rebelliousness, at least in part, motivates the non-compliance. “Yes-but” patients are particularly good candidates for this approach. This type of intervention gives the physician a way to help non-compliant, rebellious patients. Rebelliousness in fact serves as motivation to make changes. Although highly useful, this type of intervention is sometimes more difficult to deliver since it requires the communication of two seemingly contradictory messages. The direct communication is I care for your well being but change may be too difficult for you so don’t change. The indirect message is, I believe you really want to change. For this reason some family doctors elicit the help of a therapist experienced in these interventions. For those however who have the time and inclination to gain the experience it can be a useful and powerful aid for treating a difficult group of patients.

The decision to use a restraining directive most often occurs after a more direct request for change has been resisted. A useful way then to introduce a restraining directive is for the doctor to explain that it was a mistake for the doctor to request the patient or family to perform the task. Wording such as, “it was too much to ask you to make such a change” is commonly helpful. It is often useful to spell out the needs the problematic behavior may be fulfilling for the patient or family and why there is a disincentive to change or make change. “Because of your problems you are very needy now and if you do more for yourself, others will do less.” The therapist then suggests that the patient not change or perhaps suggests refraining from change for a while, or at least change extremely slowly.

For example, a 60-year-old man, D. R., suffers a serious M.I. His wife, who had been an excellent caretaker, died several months before his heart attack. Despite significant damage to his heart he makes a good initial recovery. When it comes time to rehab, however, he becomes more dependent on nursing staff and family, and makes excuses daily on why he can't participate in rehab activities. The nursing staff becomes increasingly frustrated by such behaviors such as calling them to hand him a glass of water or push the TV remote buttons. Some family members feeling sorry for him, perform these activities for him regularly.

When direct encouragement and reassurance fail to improve this over dependent, sick behavior a restraining directive is attempted. The patient is told "pushing him to become more active, might have been a mistake, even if you are physically capable. The health care team mistakenly believed you wanted to get stronger as fast as possible. However, the health care team is now divided on how they should proceed. Some believe that you who have suffered so much over the past several months deserve to be taken care of much more, even if it means you may not recover as well. Others believe you really do not like being dependent and want to work as hard as possible to become independent. I, as your doctor, am not sure who is correct, but I will tell the staff to not expect much change." The doctor then gives the restraining directive, "maybe for now, since you have suffered so much it is best for you to accept all the caretaking you can get and not push yourself to get better too fast. The staff will just have to accept a less than optimal recovery." This intervention was given with family present. The patient continued to rebel against the staff, but now the rebellion took the form of more independent behavior and good rehab performance.

When improvement follows a restraining directive it is important to give the patient full credit for improvement to the point of expressing surprise that it occurred, allowing the patient to feel a victory in the success.
Furthermore, if a restraining technique has been successful it is important to continue what is working. It is therefore not a time to begin to be encouraging. The doctor can give positive feedback to the patient for their improvement while at the same time continue to restrain them from further progress. For example in the above case following progress the physician said, "I am impressed by your work in rehab. I, however, am concerned about your getting better too fast, since this might lead others to expect too much of you and not give you enough caretaking which you deserve after having gone through so much." This continued to motivate the patient.

The four above mentioned techniques are just four ways which have been useful to alter the way patients view their problem and the sequence of events surrounding it. Indeed, any creative way to help the patients to change while lowering resistance can and should be used.

Usage of Medication

Medications for psychiatric problems have been found to be very effective in many circumstances and are the sin quo non of treatment of others. They are very time-efficient for the physician. Furthermore, patients often prefer them over alternatives such as brief therapy because they act quickly, require little in the way of lifestyle change and therefore are much easier for them. Unfortunately, because of their effectiveness and appeal there has, at times, been an over-reliance on medication.

Take for instance the following commentary from the Journal of Nervous and Mental Disease entitled "What should doctors do in the face of negative evidence?" The editor writes, "Fisher and Fisher call attention to an ostensible contradiction which raises fundamental questions about knowledge and action in medical practice. Although every one of the 13 published double-blind placebo-controlled clinical trials with antidepressants fails to demonstrate an advantage for active drug over placebo in treating adolescents, physicians wrote 4 to 6 million such prescriptions in 1992 for children 18 and under." (Eisenberg, 1996).

The commentary goes on to say that physicians often prescribed medication because they want to do something even when drugs are not proven effective. This is no doubt true and very understandable especially when patients are seeking medications.

However, we also note that patients often don't continue antidepressant medicines past a year even on the recommendation of their physician. (reference) This can lead to relapse, and a cycle of medication, discontinuing medication, then relapse, etc.

In this manual we take a conservative approach to medication. That is, we suggest medication only when there is scientific support in terms of double blind controlled studies (i.e. evidence-based approach). In the common situation where either medication or brief therapy approach is about equally effective, such as in the case of certain anxiety disorders and depressive disorders, we recommend engaging the patient in an informed decision making process, letting them know the advantages of each of the approaches and deciding with the patient which may be most suitable in their circumstance. We agree with the commentary in the Journal of Nervous and Mental Disorders that physicians want to do something for their patients. It is our view that there are often effective alternatives to medications which family physicians are quite capable of undertaking and which often patients prefer once the benefit/risk of alternatives are understood. In some circumstances, medications will turn out to be the treatment of choice and for others may be a brief psychological intervention. Some clinicians speculate that even when efficacy is equivalent in these two treatment alternatives, that brief psychological interventions are better than medication strategies since patients are more likely to learn self-help skills and make attitude and lifestyle changes that may either prevent relapse or help them cope with illness more effectively in the case of relapse. Finally, in some clinical

situations a combination of both medication strategies and psychological interventions in complementary.

The following review of medication usage is only meant to introduce a basic approach to the use of psychotropic medications for different problems. A more complete discussion appears in the chapters on the specific problems and diagnoses.

The clearest indications for psychotropic medications is in the most severely debilitating disorders, for example antipsychotic medication for the treatment of schizophrenia. These psychotropic agents have revolutionized the treatment of psychosis, relieved much suffering of both patients and families, and helped to reduce the census of state hospitals throughout the country. The effect of older antipsychotic, neuroleptic drugs on the positive symptoms of schizophrenia such as loose associations, hallucinations and delusions are essential to treatment of this condition. Unfortunately, therapeutic effect was virtually coupled to potential side effects, most importantly extrapyramidal and tardive movement disorders. New generation antipsychotics, also called atypical or novel antipsychotics, carry less risk of these problems and also show benefit for the negative symptoms of schizophrenia including amotivational state, apathy, social withdrawal, etc.

Medications for the treatment of bipolar disorders have also proven very beneficial. Lithium and antiepileptic, such as valproic acid, play a significant role in the treatment of bipolar illness. Many patients with bipolar disorder can lead nearly ordinary lives while taking these drugs for prophylaxis. While there are associated side effects, most patients tolerate these well, except when interested in pregnancy.

Studies of medications for depressive disorders in adults show a clear advantage of anti-depressants over placebos. The general classes of antidepressants, monoamine oxidase inhibitors (MAOI), tricyclic antidepressants (TCA), and selective serotonin reuptake inhibitors (SSRI) all show equal effectiveness. Therefore, most decisions as to which medication to use are based on side effect profiles and matched to patient susceptibilities. In general, it is wise that family physicians to become familiar with two agents in each class thought some who do a great deal of office psychiatry may also wish to learn a broader armamentarium. Most family physicians do not use MAOIs enough to become comfortable with them, particularly because of the dietary restrictions and potential drug interactions associated with them.

Tricyclic antidepressants are generally less expensive than SSRIs and are also useful for short term treatment of insomnia. Several pharmacoeconomic studies, however, have shown that the cost of office visits, hospitalizations, and the burden of side effects of tricyclic antidepressants actually make their prescription more expensive than SSRI alternatives. They can have utility in anxiety disorders and in the treatment of chronic pain. However, the do have numerous

side effects, which many patients find intolerable such as sedation and anti-cholinergic effects. They are also are highly lethal in overdose making them dangerous for the depressed, suicidal patient. The TCAs have a low therapeutic to toxic ratio, no antidote and they are not dialyzable. Potential cardiac side effects also have factored to decrease the popularity of these once widely prescribed antidepressants. They remain, however, a viable treatment choice for certain patients, especially when the physician undertakes to treat depression along with some other problem responsive to TCA and in the occasionally recalcitrant depressive patient requiring combination therapy.

The SSRIs are usually much better tolerated, though they are more expensive. Side effects may include gastrointestinal disturbance, sexual dysfunction (except citalopram), and increased anxiety/insomnia (less likely with paroxetine).

Brief psychological therapy has been shown to be about equally effective to medications for depressed patients, however, whereas medication strategies usually begin to take effect in 2-6 weeks, brief therapy often takes two months before significant benefits are realized. A more complete discussion of medications as well as brief psychological therapy for depression is undertaken in the chapter on that subject.

Several classes of medication have shown therapeutic effect for the treatment of anxiety disorders. Anxiolytics such as benzodiazepines are helpful for anxiety disorders in the short term. However, their long-term benefit is questionable and they do tend to reduce the patient's motivation to work on the cause of their anxiety. Inducing drug dependence or addiction is a concern with this class. The benzodiazepines may impair cognition especially in the elderly and in those with an already impaired central nervous system. Automobile and home accidents are increased in those receiving benzodiazepines. Subtle changes in socialization and motivation may also occur and be very difficult to recognize as a side effect even though causing significant change in equality of life and interfering with therapeutic benefit. Benzodiazepines are best used for acute anxiety in order to help a person get back to their usual activities.

For more specific types of anxiety such as panic disorders or the phobias, SSRIs have been of some benefit. To avoid initial exaggeration of existing anxiety these drugs should be started at a very low dose and increased slowly in order to desensitize certain serotonin pathways involved in anxiogenisis. Beta blockers have been used to control adrenergic physical symptoms e.g. tachycardia, tremor, and panic disorder. Obsessive/compulsive disorder may respond to antidepressants or buspirone.

Long term treatment of generalized anxiety disorder may be undertaken with buspirone. This non-sedating, non-benzodiazepine anxiolytic has few side effects beyond gastrointestinal disturbance. Drug reactions are rare and buspirone is non-addictive. Some controversy exists regarding effectiveness.

In general, since there are good psychological treatments for anxiety disorders, which have been shown to be at least equally effective to medications with less potential for side effects and greater potential for lasting personal growth and change to prevent or self-treat relapse, brief psychological interventions probably represent first line treatment of anxiety disorders. A more complete discussion of this can be found in the following chapters on this subject.

Treating insomnia with sedative/hypnotic agents for a short duration not exceeding two weeks can be effective, easy and inexpensive. However, the long-term treatment of insomnia with pharmacoactive agents should be avoided unless the myriad causes of reversible insomnia have been investigated and ruled out. Over the counter medications, which usually contain antihistamines, are somewhat effective but quickly lose their positive effect if used longer than two weeks. These agents also carry a significant risk for anticholinergic side effects especially in the elderly. The delirium, dry mouth, constipation, fecal impaction and urinary retention are possible. Because of their safety and efficacy, low cost hypnotics such as the benzodiazepines are the most common treatment choice. They too induce tachyphylaxis and do not really affect sleep in a positive way beyond two weeks. The chronic user who stops, however, will experience insomnia as a withdrawal phenomena. This falsely corroborates the patient's belief that they still need the drug to sleep. Because of addiction potential, benzodiazepines should rarely be used in patients with a history of substance abuse. Once used, they should be tapered slowly after a week or two to prevent rebound insomnia. Short acting hypnotics might be better choices when sleep onset is the primary problem while longer acting drugs would seem more reasonable if terminal insomnia is present although "hangover" next day sedation can be a problem with these agents. In addition to the problem of rebound insomnia there are alterations in sleep cycle that may lead to less "natural" and less efficient sleep with benzodiazepines. Newer GABA selective sedative drugs have recently become available and have significant advantages over older benzodiazepines. The highly sedating antidepressants are frequently best for long term treatment of insomnia when other means fail.

For most patients a sleep hygiene program such as the one described in the chapter on insomnia works sufficiently well to avoid the use of prescription drugs.

When to Refer

The decision on when to refer in most situations need not be complex. For the most part a brief intervention used by a family physician will work as long as the problem is of short duration. When the problem has developed in the last few months, usually patients get back to their usual level of function with brief therapy. This is true even when problems are serious, such as major depression, as long as they are not a long-standing problem. Depression can take four months or more to resolve but behavioral change should be noted after two or three appointments. If the problems are unresponsive to treatment within a

couple months the doctor should consider referral. The consulting therapist, psychologist or psychiatrist will also have a greater chance of successful treatment if the problem is not yet chronic.

Long term problems are much more difficult to treat, take longer and therefore usually are best referred. Family physician experience and patient preference, of course, must also be considered.

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