Combining Pharmacotherapy with Psychotherapeutic Management for the Treatment of Psychiatric Disorders

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Pretest

1. Modalities necessary for adequate treatment of most Axis I disorders over the long-run include:

   a. individual psychotherapy
   b. medication
   c. rehabilitation
   d. family intervention
   e. all of the above

Pretest

2. A basic rationale underlying combined therapy includes:

   a. correct the presumed biochemical deficit
   b. use the “window of opportunity” provided by the suppression of symptoms to remold both cognition and behavior
   c. When using family intervention, have the patient actually change behavior before getting “insight”
   d. All of the above

Pretest

3. All of the following, except one, have controlled data suggesting the adding psychotherapy improves outcome above what medication alone provides:

a. Schizophrenia
b. Pervasive Developmental Disorder
c. Bipolar Disorder
d. Major Depressive Disorder
e. Bulimia Nervosa

Pretest

4. Advantages of combined therapy include all of the following except one::

   a. Increased cost in the short run
   b. For those patients biologically-oriented, psychotherapy promotes a sense of increased collaboration and targets intrapsychic and interpersonal problems
   c. Medication can improve psychotherapy compliance
   d. Family therapy can improve increase medication compliance

Pretest

5. Disadvantages of combined therapy include all of the following except:

   a. With medication, increased risk for side effects and early termination of all therapies
   b. Faster response than either modality alone
   c. With psychotherapy, perceived need for medication decreased (“I can solve this on my own”)
   d. Increased cost of treatment
   e. Slower response than either alone

Teaching Points

- **To improve "outcomes" for most psychiatric disorders, one must combine psychotherapeutic/rehabilitation strategies with medication strategies.**

- **To effectively deliver combined medication and psychotherapeutic treatments, this lecture provides guidelines on how to integrate the therapies (including sequencing, structure of sessions, goals, etc.).**

Teaching Points (cont'd)

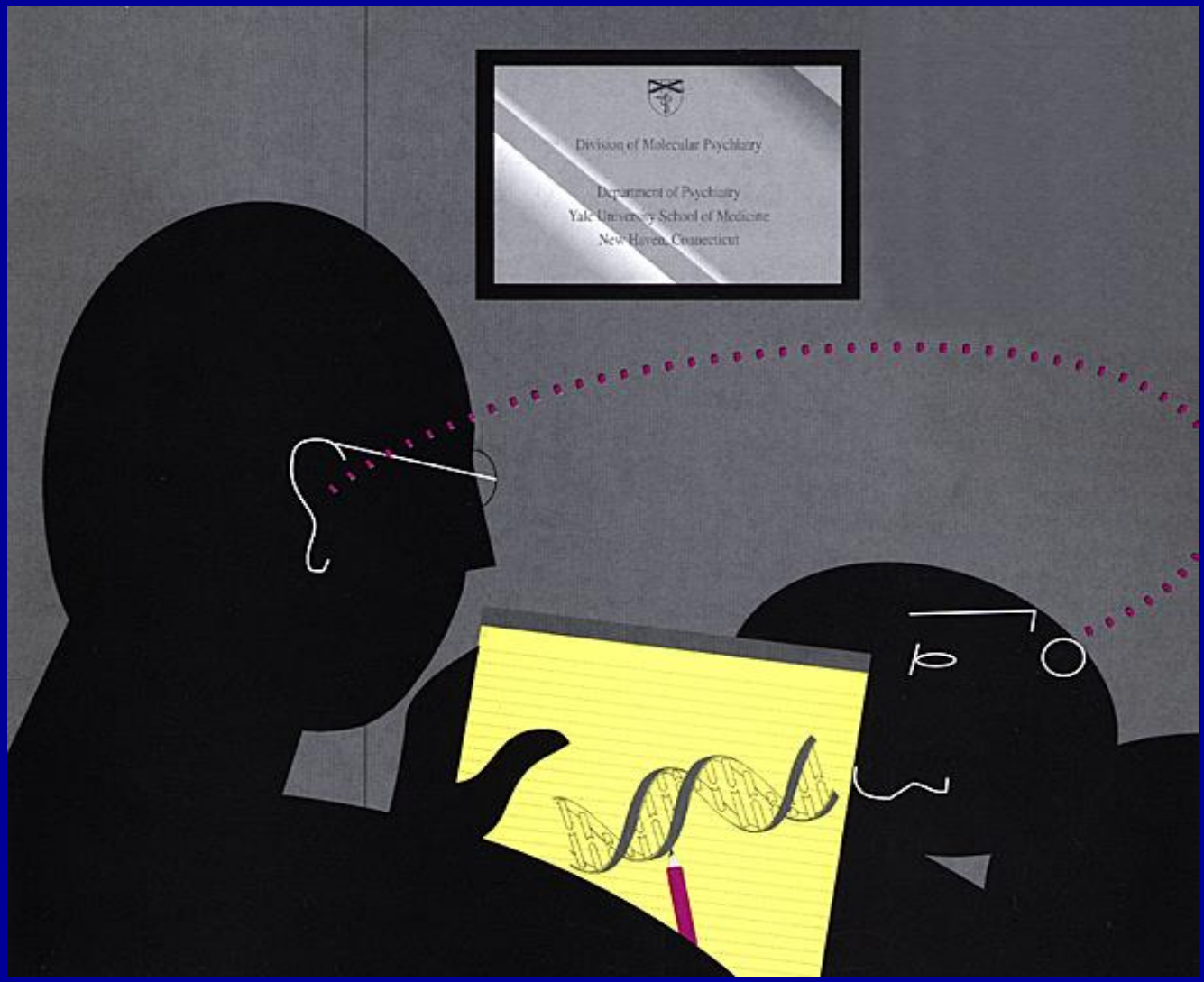
- Because this is a psychopharmacology course, and because this is designed as a one hour lecture, broad guidelines for "how" to combine are presented with psychotic disorders as a focus. The student may be referred to the large existing literature on which type of psychotherapy (for example CBT) for which disorder (for example, mood disorders, anxiety disorders or OCD). See references at end of lecture.

- Basic guide: Riba MB, Balon R: Competency in combining pharmacotherapy and psychotherapy. Integrated and split treatment; APPI 2005

Issue

What does psychotherapy add above what medication alone provides?:

- in what conditions?
- for which patients?
- at what phase?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Outline

- **Introduction**
  - Rationale and Model
  - Theoretical Outcomes
- Results
- Guidelines
- Summary and Clinical Implications
  -

Reasons Why Combined Therapy not Delivered

- Many providers deliver one or the other
- Most insurers pay for non-integrated treatment
- Many professionals trained in one or the other
- Provider bias

Integrated vs. Collaborative treatment

- **Integrated treatment** – pharmacotherapy and psychotherapy provided by one person
- **Collaborative (or split) treatment** – pharmacotherapy and psychotherapy provided by psychiatrist and therapist (psychologist, social worker, counselor)

Rationale for Combining Medication and Therapy

- Patients value psychotherapy
- Patient may not be on medication
- Etiology
  - Although biological, “stress” may precipitate episode
- Pathogenesis
  - Illness has effects on the family
- Treatment
  - To improve adherence
- It may work better than one modality (medication or therapy)

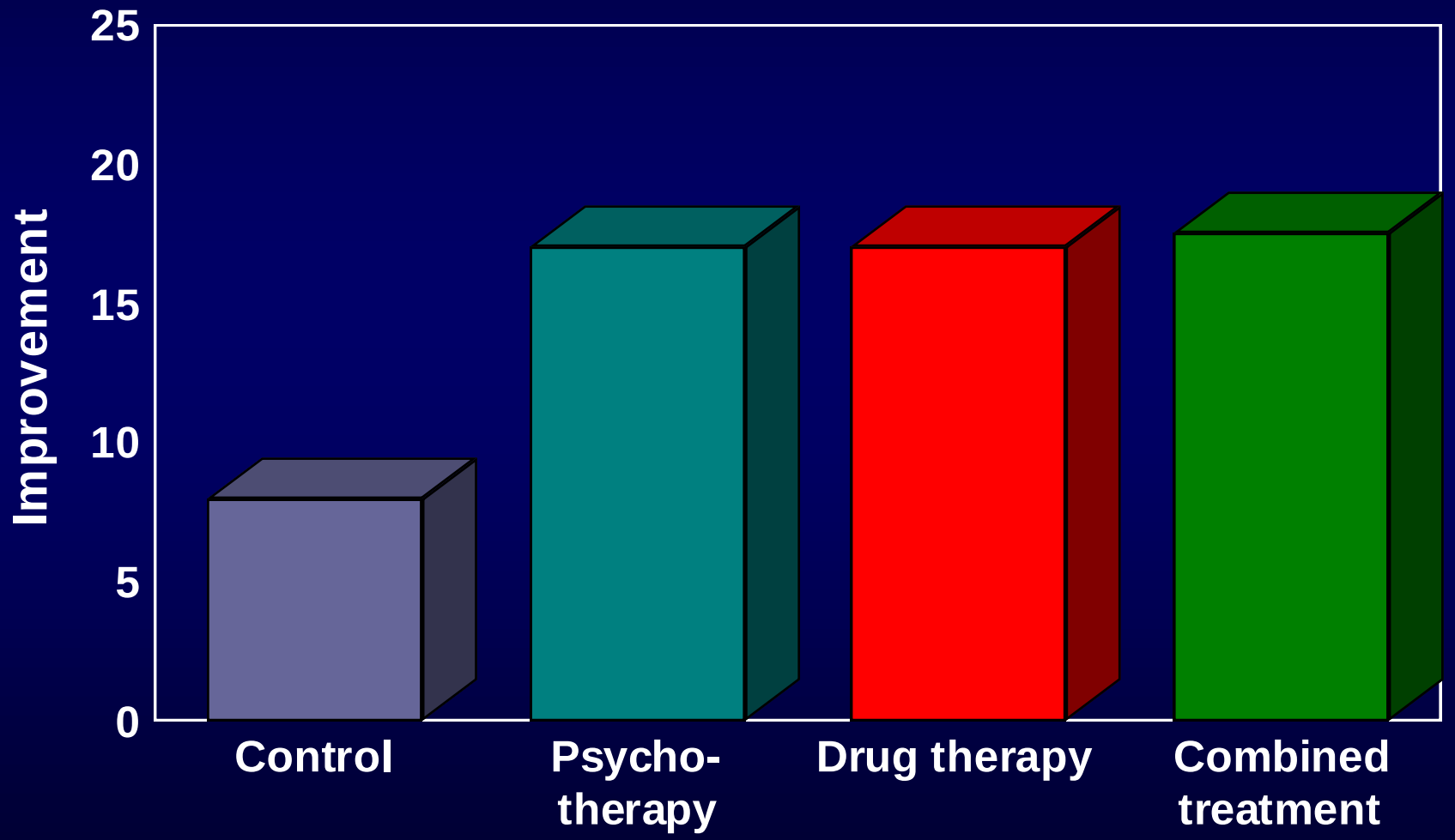
Reasons Why Psychotherapy is Important

- Some conditions have no effective pharmacotherapy treatment available
- Medication may be contraindicated
- Patient may not want to take medication (numerous reasons)
- Most patients have social and interpersonal problem accompanying Axis I disorders either as the source of or are the consequence of the illness

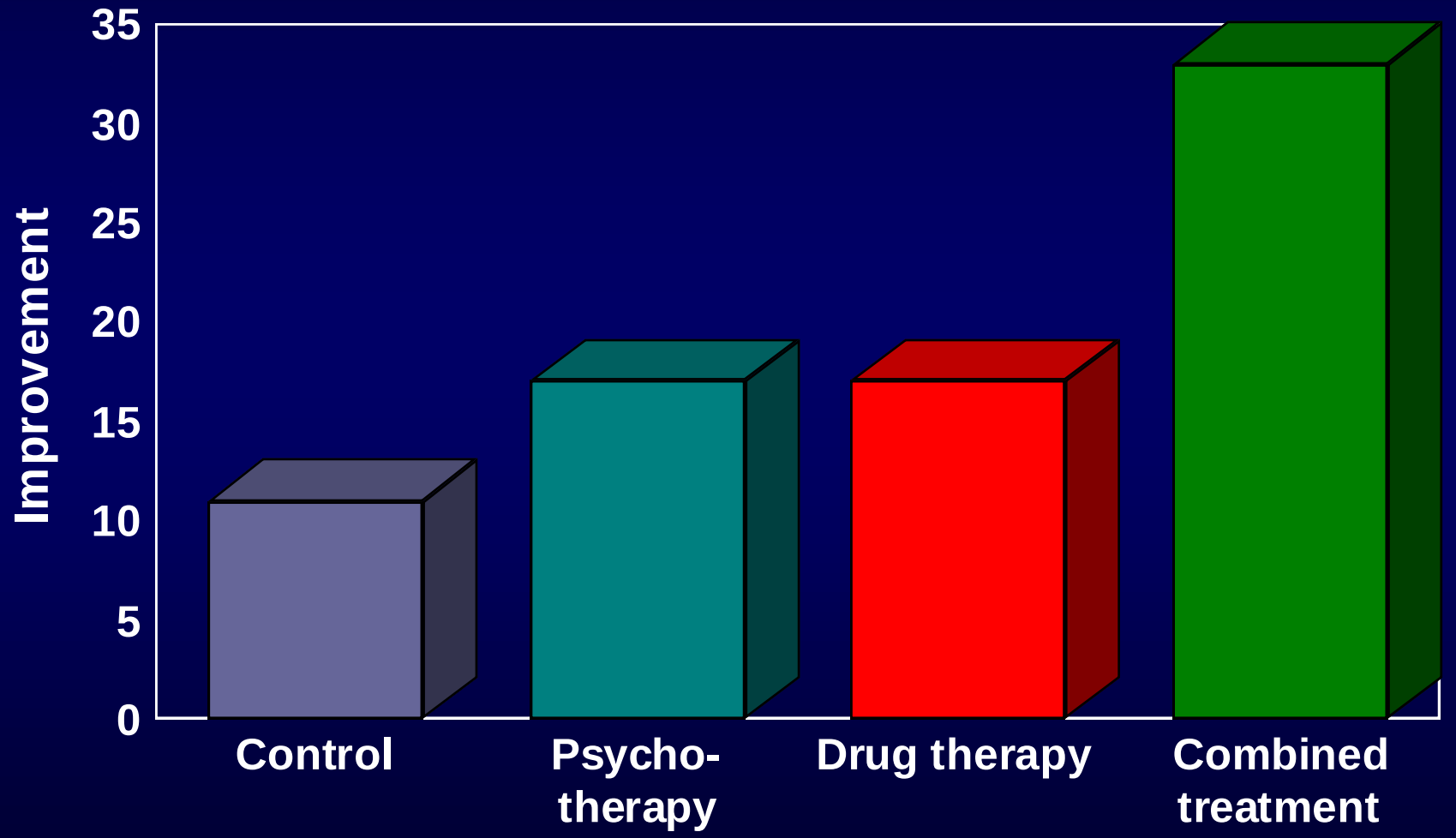
Outcomes of Combined Treatment

- Positive effects
- Negative effects
- No effect

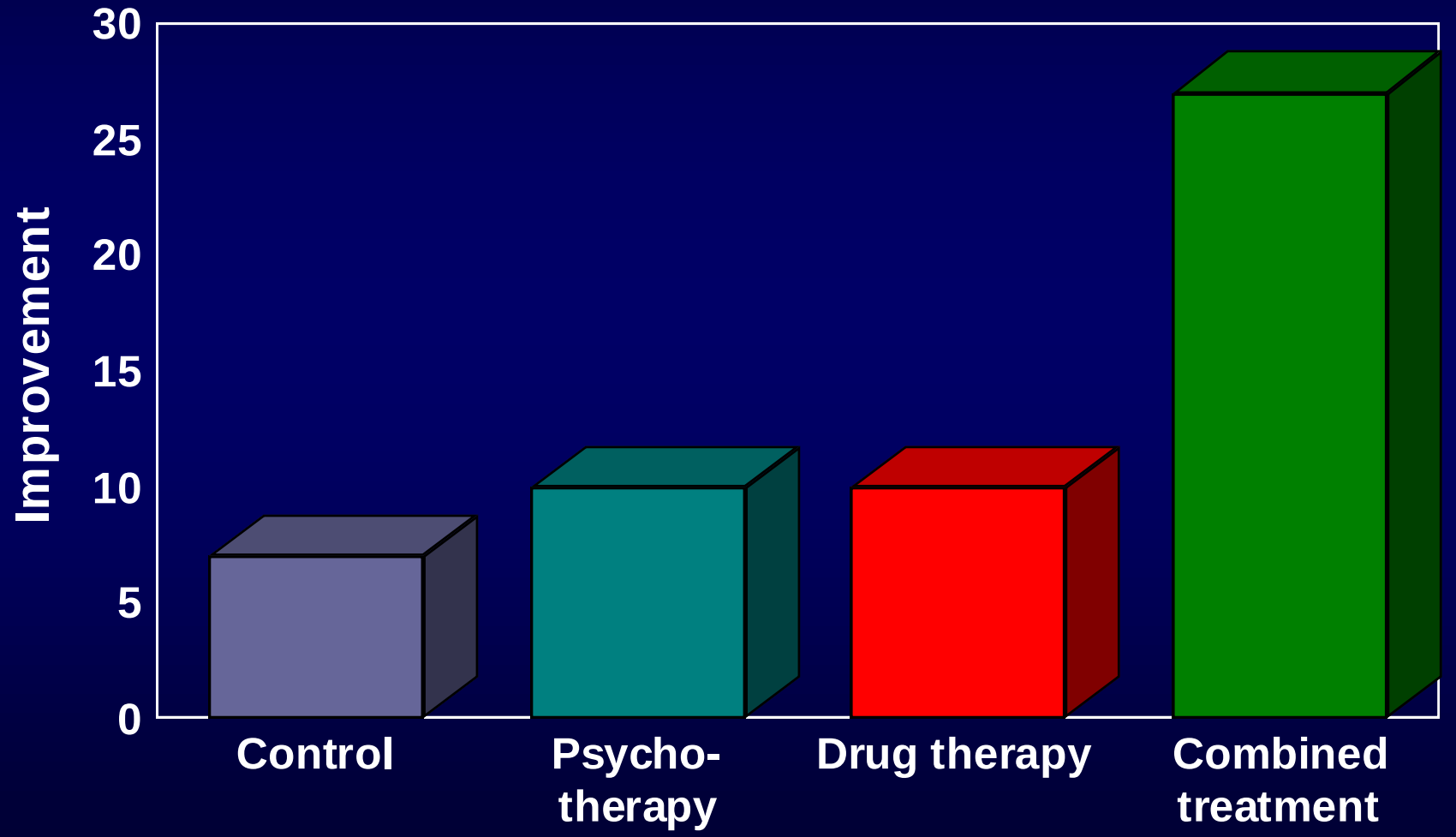
Combined Treatment Outcome
No Additive Therapeutic Effect



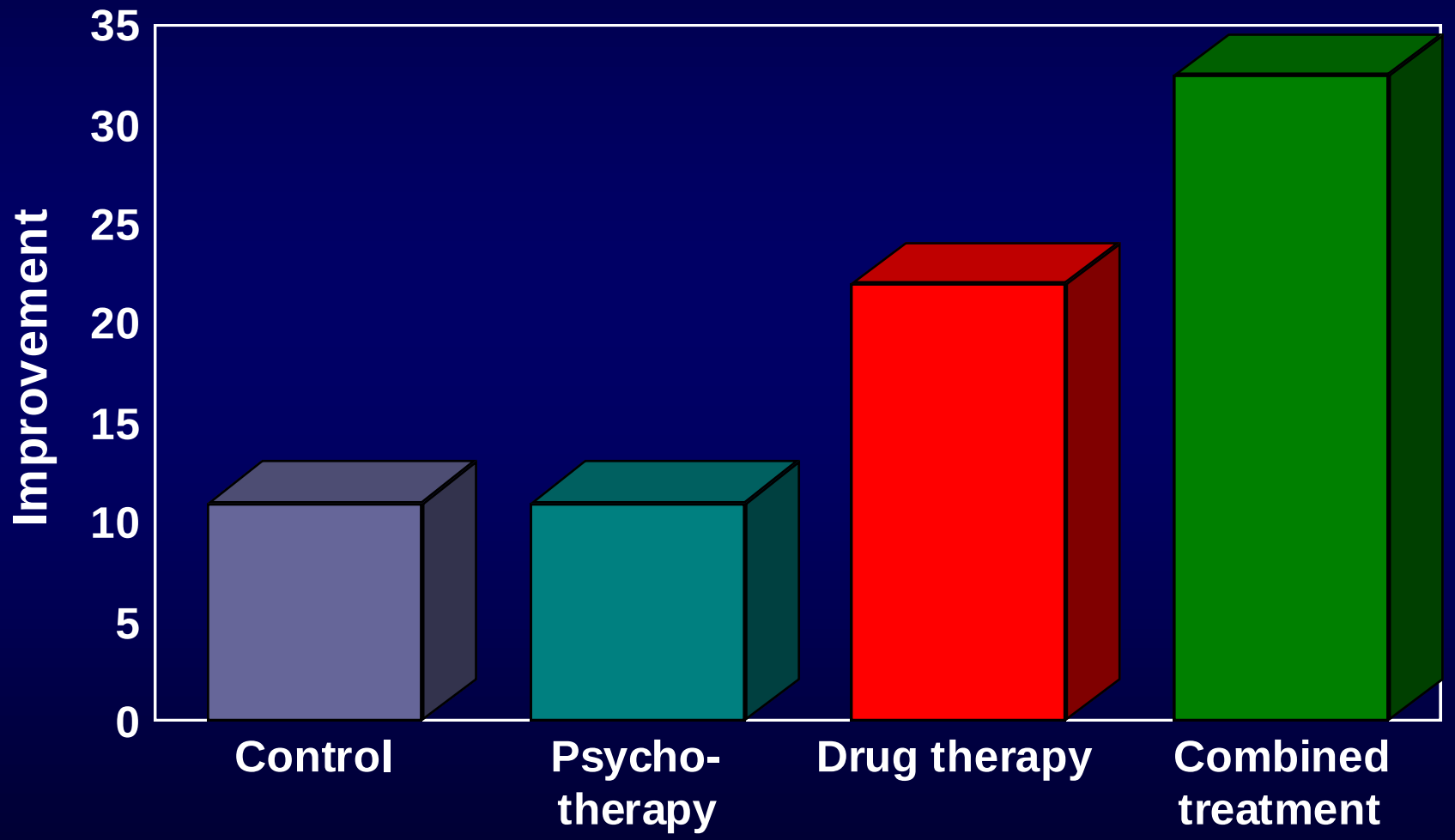
Combined Treatment Outcome Positive Effect — Additive



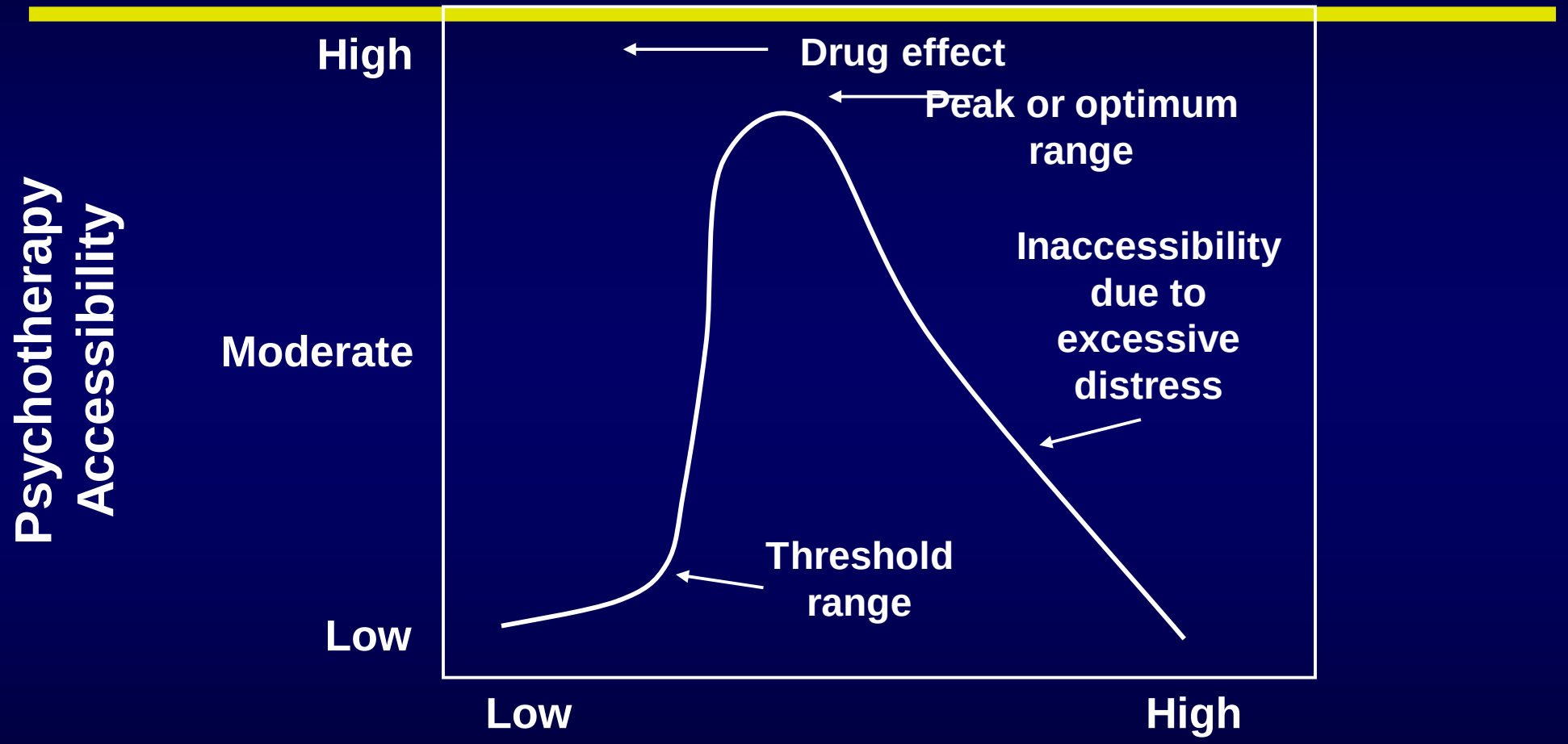
Combined Treatment Outcome Positive Effect — Synergistic



Combined Treatment Outcome
Positive Effect — Facilitative



Medications Facilitate Accessibility to Psychotherapy



Outline

- Introduction
  - Rationale
  - Theoretical Outcomes
- **Results**
- Guidelines
- Summary and Clinical Implications

Results

- Controlled Research - examples TSS
- Guidelines and Algorithms
  - For schizophrenia - <50% received adequate treatment (Lehman et al, 1998)
  - For depression - consistent undertreatment (Keller et al, 1997)

Drug-Psychosocial Interactions in Schizophrenia

- Psychosocial treatments more effective when psychotic symptoms are controlled with drugs (May et al, 1968)
- Psychosocial treatments can be toxic when patients not adequately treated with drugs (Hogarty et al, 1974)
- Psychosocial treatments more effective when compliance is assured (Hogarty et al, 1979)

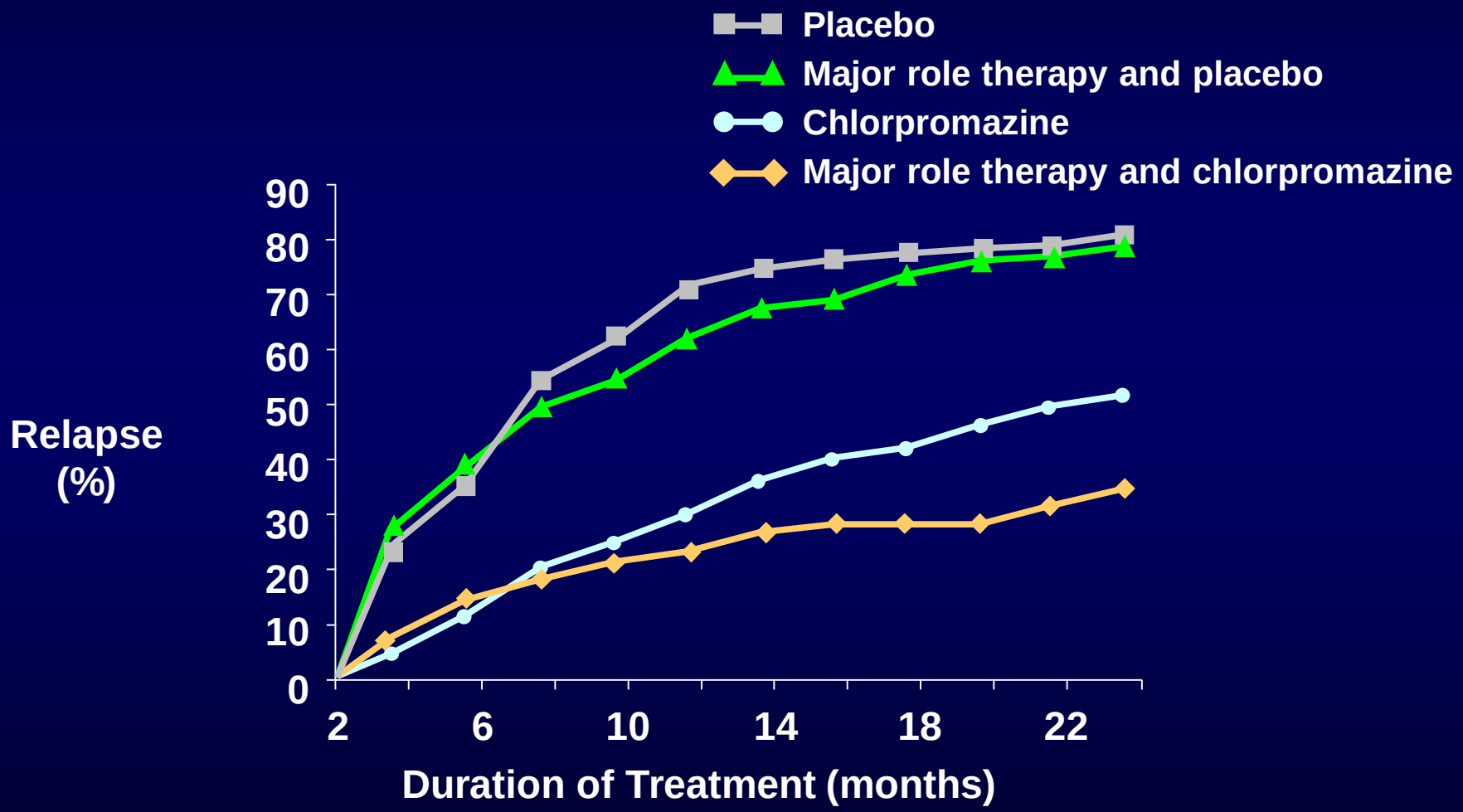
May PRA. *Treatment of Schizophrenia: A Comparative Study of Five Treatment Methods*. New York, NY: Science House; 1968.
Hogarty GE et al. *Psychopharmacol Bull*. 1974;10:47.
Hogarty GE et al. *Arch Gen Psychiatry*. 1974;31:603-608.
Hogarty GE et al. *Arch Gen Psychiatry*. 1974;31:609-618.
Hogarty GE et al. *Arch Gen Psychiatry*. 1979;36:1283-1294.

Drug-Psychosocial Interactions in Schizophrenia

- Drugs may be more effective when compliance is enhanced by psychosocial treatment (Marder et al, 1996)
- Drugs and psychosocial treatments may affect different outcome domains, ie, drugs control symptoms and psychosocial treatments affect social adjustment (Marder et al, 1996)

Marder SR et al. *Am J Psychiatry*. 1996;153:1585-1592.

Cumulative Relapse Rates in Schizophrenia



Goldberg SC et al. *Arch Gen Psychiatry.* 1977;34:171-184.

Trials Combining Medication With Psychosocial Treatments (Both Controlled)

	N	Medication (MED)	Psychosocial Treatment (PST)	Outcome	Result
Hogarty et al. (1973, 1974)	360	Chlorpromazine	Major role therapy	Relapse	>1 y: MED + ↑ PST
Hogarty et al. (1979)	105	Fluphenazine	Social therapy	Relapse	>1 y: MED + ↑ PST
Hogarty et al. (1986, 1991)	90	Fluphenazine	Family treatment, social skills training	Relapse, expressed emotion	1 y + 2 y: MED + ↑ PST
Schooler et al. (1997)	313	Fluphenazine	Psychoeducation vs family therapy	Rehospitalization symptoms	No difference between 2 PSTs
Marder et al. (1996)	80	Fluphenazine	Behavioral skills training, supportive group	Relapse, social adjustment	MED + PST adjustment ↑

Newer Antipsychotics and Quality of Life

- 1-year double-blind comparison of clozapine and haloperidol
- Clozapine-treated patients more likely to participate in psychosocial programs
- Participation in psychosocial treatment reduced symptoms and improved quality of life

Rosenheck R et al. *Arch Gen Psychiatry*. 1998;55:618-625.

*Table 1. Summary of Disorders In Which Psychotherapy Improves Outcome Over Medication Alone

Disorder/ Syndrome	Treatments	Standard of Proof
Bipolar disorders	While pharmacological interventions are treatments of choice, psychosocial treatments, including psychoeducation, cognitive behavior therapy, IPSRT, and marital/family therapy, have shown the potential to increase medication adherence, improve quality of life, and enhance mechanisms for coping with stress in patients with bipolar disorder.	Several Type 2 and Type 3 studies of psychoeducation; three Type 1 studies of cognitive behavior therapy; one Type 1 study of IPSRT; and several Type 1 studies of marital/family therapy.
Childhood attention-deficit hyper-activity disorder (ADHD)	Combining intensive behavioral intervention with well-delivered pharmacological agents typically ranks better than either treatment component alone; this is the only modality that tends to normalize behavior patterns.	One very large-scale Type 1 clinical trial comparing behavioral intervention alone and medication alone with the two together
Major depres-sive disorder (MDD)	At least one major study lends strong support for the superior effectiveness of combined psychosocial and pharmacological treatment	One type 1 RCT

*Table 1. Summary of Disorders In Which Psychotherapy Improves Outcome Over Medication Alone Con't

Disorder/ Syndrome	Treatments	Standard of Proof
Schizophrenia	Structured, educational family interventions help patients with schizophrenia maintain gains achieved with medication and customary case management	Over 20 Type 1 and Type 2 RCT's of educational family interventions
Post-traumatic stress disorder (PTSD)	Antidepressants reduced both PTSD symptoms and those of co-morbid conditions; they also made it easier for patients to benefit from psychotherapy, three varieties of antidepressants have been most commonly used	Several Type 1 and Type 2 RCT's
Sleep disorders	Behavioral interventions, including stimulus control, sleep restriction, relaxation strategies and cognitive behavioral therapy, have shown effectiveness, especially over the longer term in reducing sleep onset, decreasing awakenings, and increasing total sleep time; these behavioral interventions produce more sustained effects than pharmacological agents	A moderate number of Type 2 RCTs, in comparison to waitlist controls, partial behavioral interventions and pharmacological gents

*Studies are rated by quality of design, i. e. randomized controlled trials are the highest rated.

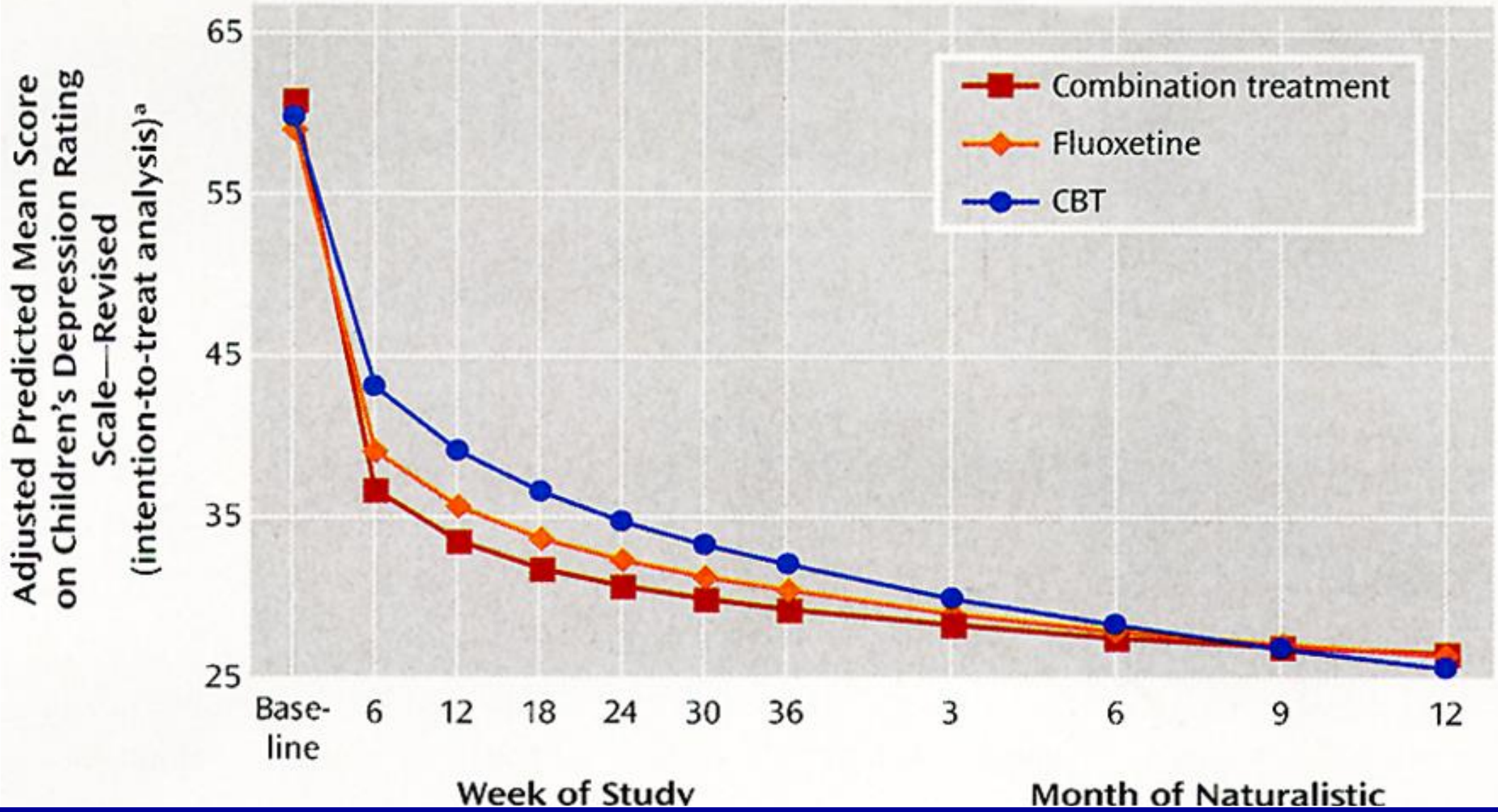
References are found in the text. From Nathan & Gorman, 2002, modified with permission

Table 1. Summary of Disorders in Which Psychotherapy Improves Outcome Over Medication Alone (cont'd)

Disorder/Syndrome	Treatments	Standard of Proof
Bulimia Nervosa (BN)		• A large number of Type 1 and Type 2 TCTs, utilizing placebo as comparison. • A very substantial number of Type 1 and Type 2 TCTs

Recent Studies Supporting Value of Adding Psychotherapy to Medication Alone for Adolescents

- Depression – TADS: CBT and Antidepressant
- Schizophrenia (early onset, ultra high risk) – McGorry: Psychoeducation and Antipsychotics
- Anxiety Disorder – CAMS: CBT and Antidepressant


Adjusted Predicted Mean Score on Children's Depression Rating Scale—Revised (intention-to-treat analysis)[a]
65
55
45
35
25
Combination treatment
Fluoxetine
CBT
Base-line
6
12
18
24
30
36
3
6
9
12
Week of Study
Month of Naturalistic

Chronic Depression

REVANT trial found no substantial short-term value of CBT or of supportive psychotherapy to results achieved by flexible, pharmaco-therapy alone

Outline

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Presumed Mechanism of Action

- "Correct the presumed biochemical deficit, but then use the window of opportunity provided by suppression of the symptom to remold both cognitions and behavior."
  Malcolm Lader, 1996

- "I believe that biologically mediated impairments in abstract thinking, "executive" problem solving, and mood reactivity (i.e.,the ability to life one's spirits in response to something savory or encouraging will be found to be the clinical culprits that result from the biological alterations described above." *Michael Thase, 1998*

Table 1 - General Guidelines for Combined Therapy:

I - Diagnosis

- Make a DSM diagnosis
- Make a family systems diagnosis
- Make an individual dynamic diagnosis
- Formulate case

Table 2 - General Guidelines for Combined Therapy:

II – Goals

- Select appropriate modalities and their combination
- Develop specific goals for each modality
- Decide about sequencing
- Be aware of, and enquire about, side effects of each modality as well as their interactive effects

Hierarchy of Treatment Goals in Medical Psychotherapy of Schizophrenia

- Acute Phase
  - Medical/neuropsychiatric assessment
  - Rapid symptom reduction
  - Reduce impact of episode on friends, family, housing, activities
- Convalescent Phase
  - Gain trust/alliance with family/caregivers
  - Assess and mobilize social support
  - Ensure human service needs are met (food, clothing housing)
  - Ensure safety and predictability of environment

Hierarchy of Treatment Goals in Medical Psychotherapy of Schizophrenia (cont'd)

- Adaptive Plateau

  Establish therapeutic alliance/supportive treatment routine

  Achieve effective maintenance medication regime

- Stable Plateau

  Psychoeducation: Promote illness self- management strategies, awareness of relationship between stress and symptoms

  Rehabilitation: Teach adaptive competencies

Hierarchy of Treatment Goals in Medical Psychotherapy of Schizophrenia (cont'd)

- Selected Patients Near Recovery
  - Encourage introspection, self and other awareness
  - Encourage improved interpersonal relations, productivity, conflict management, self-understanding, self-concept

Table 3 - General Guidelines for Combined Therapy:

III - Sequencing of Combined Treatments

- Step 1 - Establish an alliance
- Step 2 - For psychotic disorders, start medication early
- Step 3 - Add individual intervention as patient is able to participate
- Step 4 - Add family intervention early. Start with psychoeducation and referral to appropriate group depending on DSM diagnosis

Table 3 - General Guidelines for Combined Therapy:

III - Sequencing of Combined Treatments

- Step 5 - Add family dynamic and systemic intervention as patient stabilizes
- Step 6 - Rehabilitation in maintenance phase
- Step 7 - Do not add another modality, if first intervention (vs second) adequate for efficacy.

Table 4 - Guidelines for Structure of Session

- Assumption: Minimum 15 minutes, maximum 60 minutes - mean 30 minutes
- Divide session in three parts:
- Part I - 5 minutes:
    - ask global questions
    - then ask about side effects and target symptoms (compared to baseline)
    - do psychoeducation
    - adjust medication

Table 4 - Guidelines for Structure of Session

- Part 2 - 20 minutes:
  - explore life events
  - explore issues of transference to “pill” and to psychotherapy
  - explore issues of countertransference

Table 4 - Guidelines for Structure of Session

- Part 3 - 5 minutes, integration of:
  - patient issues
  - family issues
  - provide final prescription of medication and summarize therapy, discussed in psychotherapy, review possible side effects, complications

Medication:

A. New Medications:

B. New Strategies:

1. Adequate (rather than inadequate dose),

but minimal effective dose (MED)

2. Continuous (rather than targeted)

3. Standard (moderate) dose (rather than low dose)

4. I-M long-acting agents for non-compliant patients (rather than po)

Medication (Continued):

C. Pharmacotherapeutic Alliance (PA, Gutheil):

1. Defined as the manor in which active efforts are made by the physician to enlist, recruit, involve patient in a collaboration around prescribing meds
2. Characteristics - flexible, prescriptive stance
3. Objective - establishment and maintenance of the PA
4. Process - shared enquiry, shared goals, mutual participation in both the experience and observing the process of using medication

Table 5 - General Guidelines for Psychotherapy

- Which type in which phase
  - family intervention early if patient cognitively impaired
  - individual intervention as patient able to participate
  - combine both with family session as needed in maintenance phases

Table 6 - Guidelines for Effective Family Intervention in Psychotic Disorder

1) A positive approach and genuine working relationship between the therapist and family.
2) The provision of family therapy in a table, structured format with the availability of additional contacts with therapists if necessary.
3) A focus on improving stress and coping in the “here and how,” rather than dwelling on the past

Table 6 - Guidelines for Effective Family Intervention in Psychotic Disorder

4) Encouragement of respect for interpersonal boundaries within the family

5) The provision of information about the biological nature of schizophrenia in order to reduce blaming of the patient and family guilt

6) Use of behavioral techniques, such as breaking down goals into manageable steps.

7) Improving communication among family members

Summary of Effects of Family Intervention and Pharmacological Intervention Including Rehabilitation

- Family Intervention
  - Education
  - Communication Skills
  - Problem Solving Skills
  - Resolution of Dynamic and Systems Issues
- Pharmacological Intervention
  - Normalize Illness
  - Suppress Symptoms

Table 7 - Guidelines for Effective Individual Intervention in Psychotic Disorder

- First - make an alliance with patient and family
- Help patient maintain self-esteem regardless of illness
- Focus on improving adherence
- Distinguish among and manage among:
  - Objective psychopathology
  - Psychodynamic issues
  - Personality conflicts/deficits from patient's life history

Problems Emanating from Misuse of the Psychodynamic Model in Axis I Disorders

1) Emphasizing the patient's personality conflicts and character pathology over the patient's overt symptom manifestations.
2) Misdiagnosing objective dependency as psychodynamic dependency.
3) Misdiagnosis of lifelong disability as psychodynamic psychopathology.
4) Labeling cognitive and other changes resulting from Axis-I disorders as a personality disorder, usually "narcissistic, borderline or histrionic."
5) Treating with psychoanalytic psychotherapy with the expectation that Axis-I symptoms will subside after personality conflicts are resolved.
6) Overvaluing the effectiveness of therapist role, i.e. transference, over the natural history of disease or medication noncompliance.

Table 8 - Psychoeducation for Combined Treatment

- Provide systematic information (repetitively) to both patient and to family about
  - signs and symptoms
  - diagnosis
  - treatment - both medication and psychotherapy
  - prognosis with and without treatment
- Aim for behavioral change in both patient and family - don’t just provide information

Rehabilitation

- When
  - Post-acute episode (Harding — over 2-3 decades function may increase)
- How much
  - As tolerated
- What
  - Program for Assertive Community Outreach (PACT)
  - Case management
  - Social skills training (Lieberman)
  - Sheltered workshops
  - Vocational rehabilitation
- Who
  - Positive and negative symptom issues
- Why
  - To achieve options that patients desire

Combined Therapy
Advantages

1) For those patients biologically-oriented, psychotherapy promotes a sense of increased collaboration and targets intrapsychic and interpersonal problems

2) For those patients psychologically-oriented, medication response relieves hopelessness associated with lack of improvement in psychotherapy as well as targeting primary S_X of illness

3) Faster response than either modality alone

4) Family therapy can ↑ medication compliance

5) Individual therapy can ↑ medication compliance

6) Medication can ↑ psychotherapy compliance

Combined Therapy

Disadvantages

1) With medication, risk for side effects and early termination of all therapies

2) With psychotherapy, perceived need for medication decreased ("I can solve this on my own")

3) Splitting

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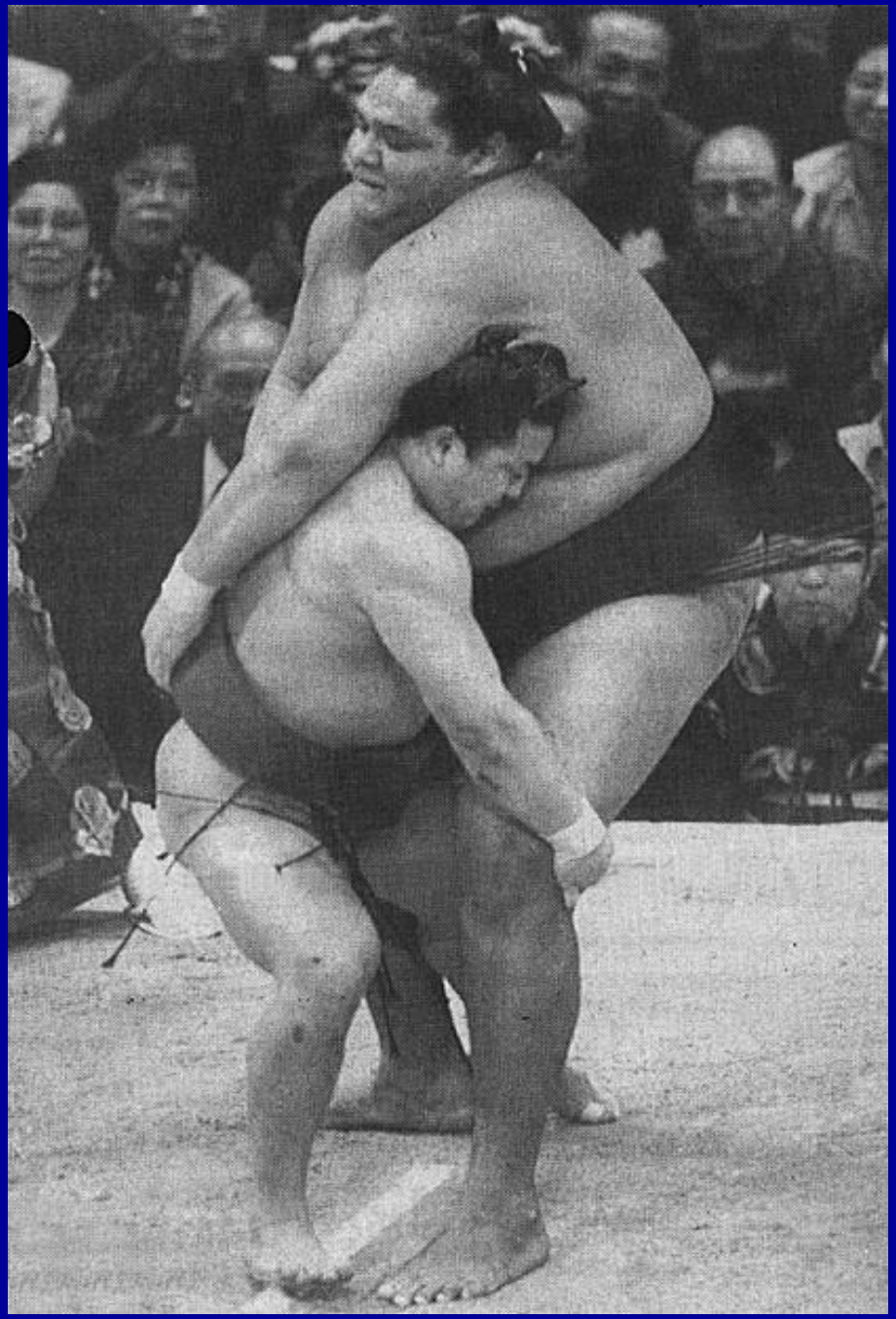
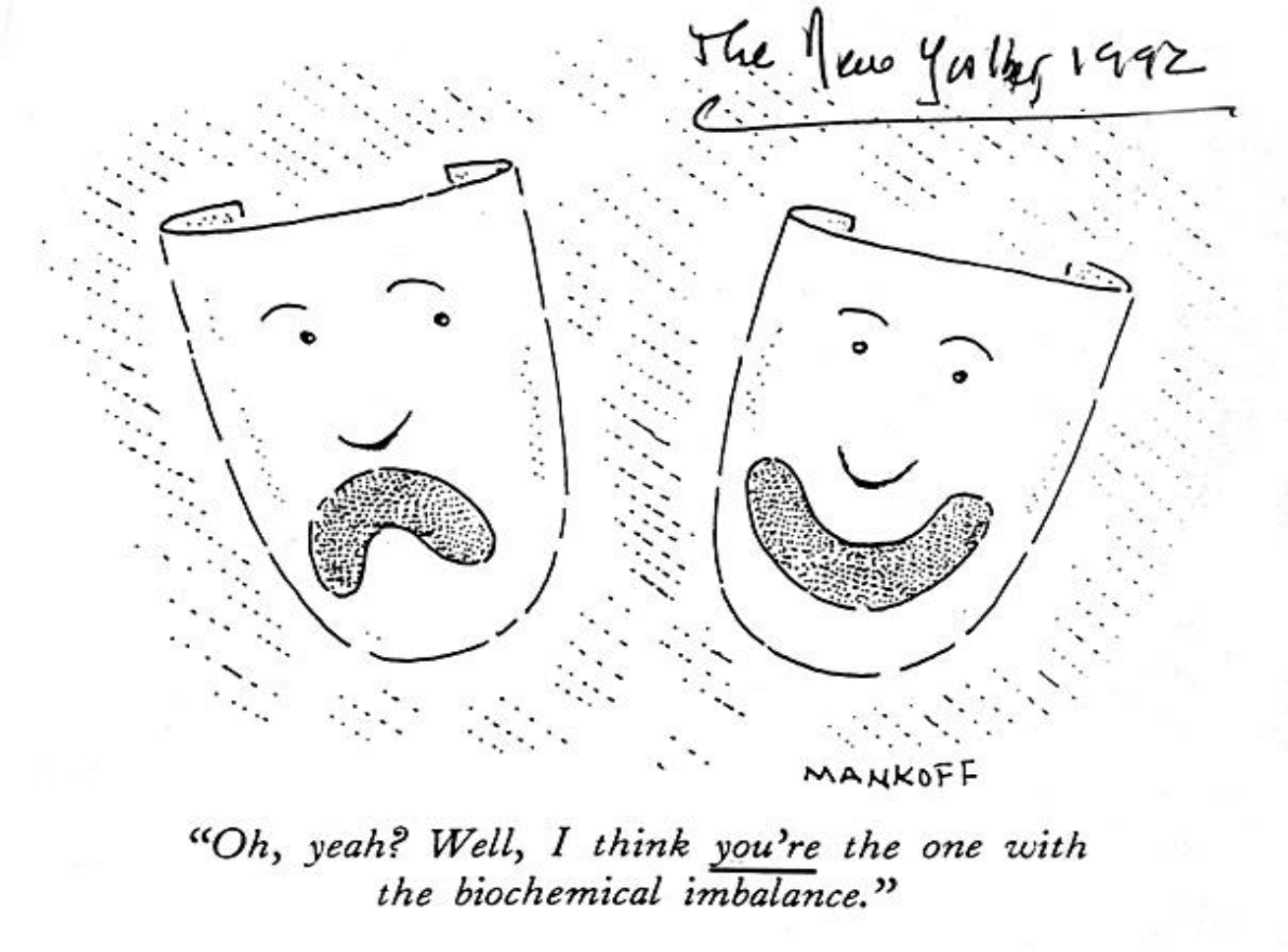


Nature via Nurture

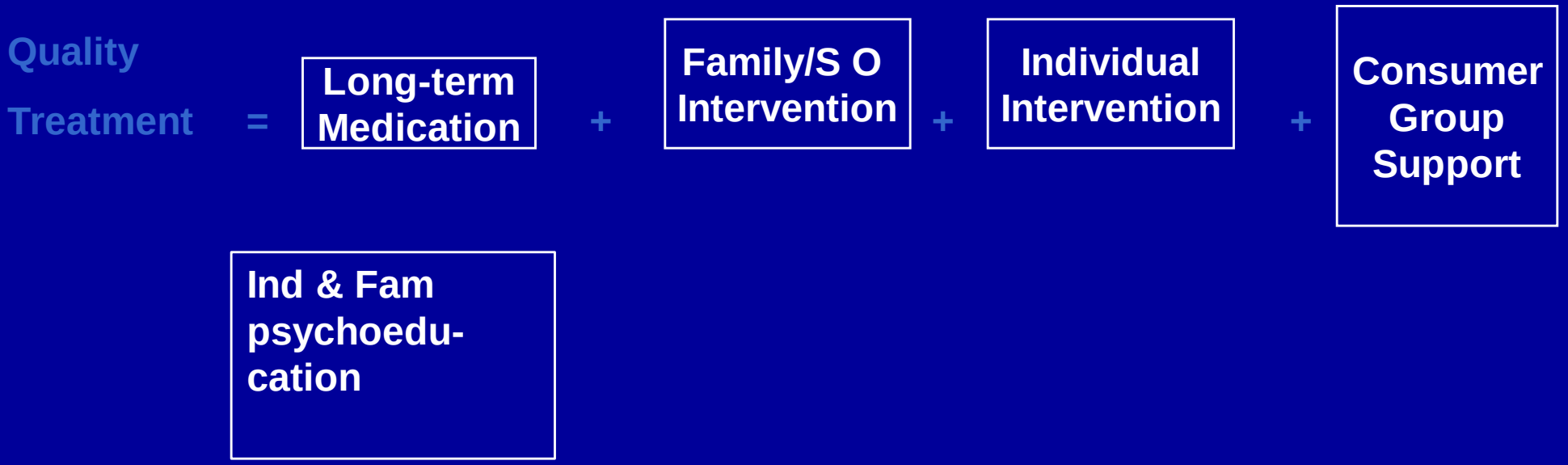
A revolution is sweeping the field of biology that holds that the influences of nature and nurture are so inextricably linked that it is difficult to speak of them as distinct forces that shape who we are. We now know that our environment can change us only if we are genetically predisposed to change and that our genes are powerless if they are not primed by the environment. When it comes to understanding our fate, we can no longer study the effect of genes of the environment without considering the interaction between them.

C.T. Gross, 2004



"Oh, yeah? Well, I think you're the one with the biochemical imbalance."

Quality Treatment Equation



Post-test

1. Modalities necessary for adequate treatment of most Axis I disorders over the long-run include:

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   d. family intervention
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Pre- and Post-Test Answer Key

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