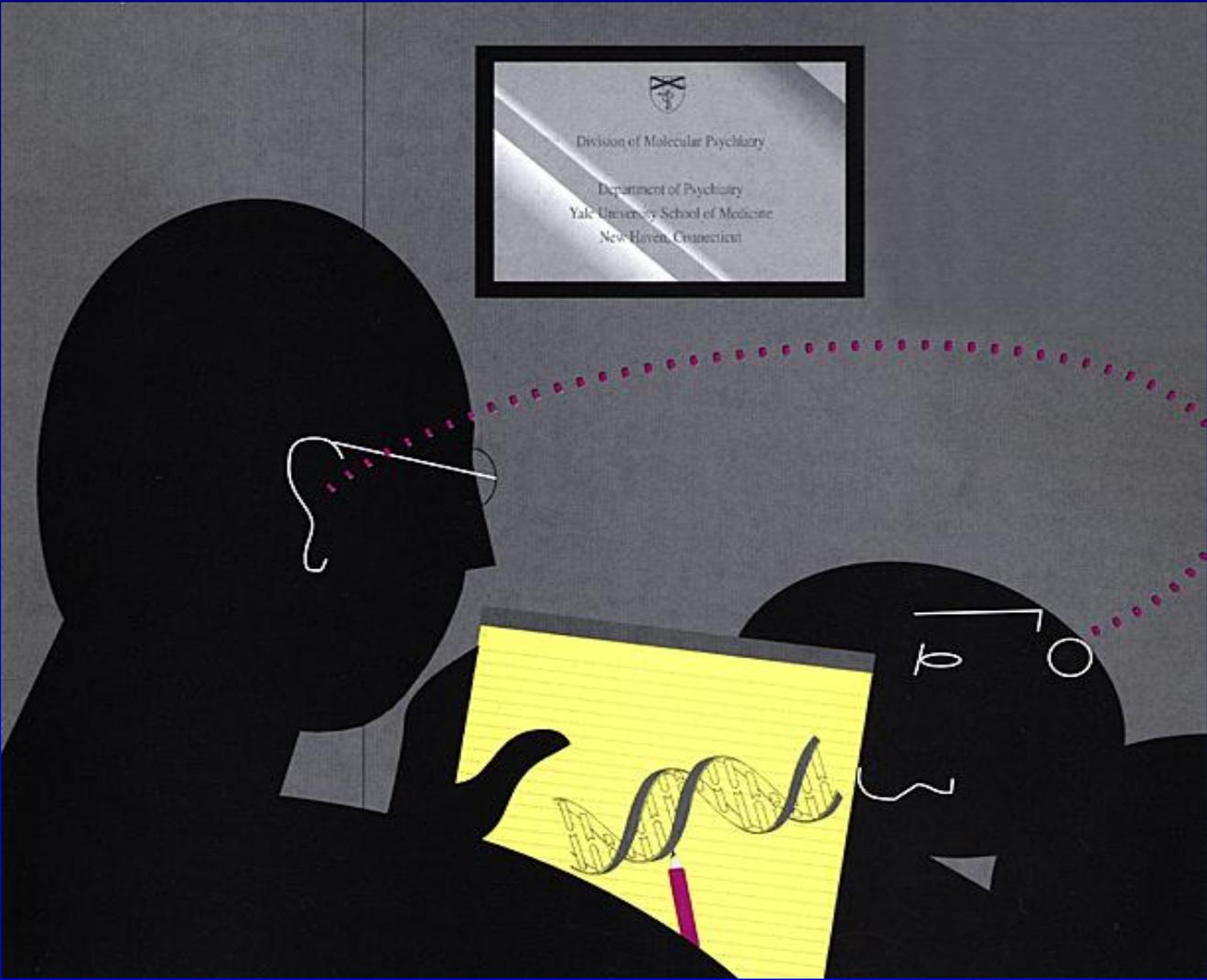
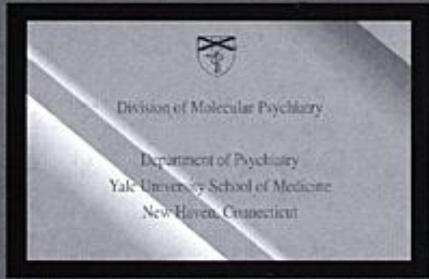


Combining Pharmacotherapy with Psychotherapeutic Management for the Treatment of Psychiatric Disorders

Ira D. Glick, M.D.
Stanford University School of Medicine





Outline

- **Introduction**
 - Rationale
 - 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

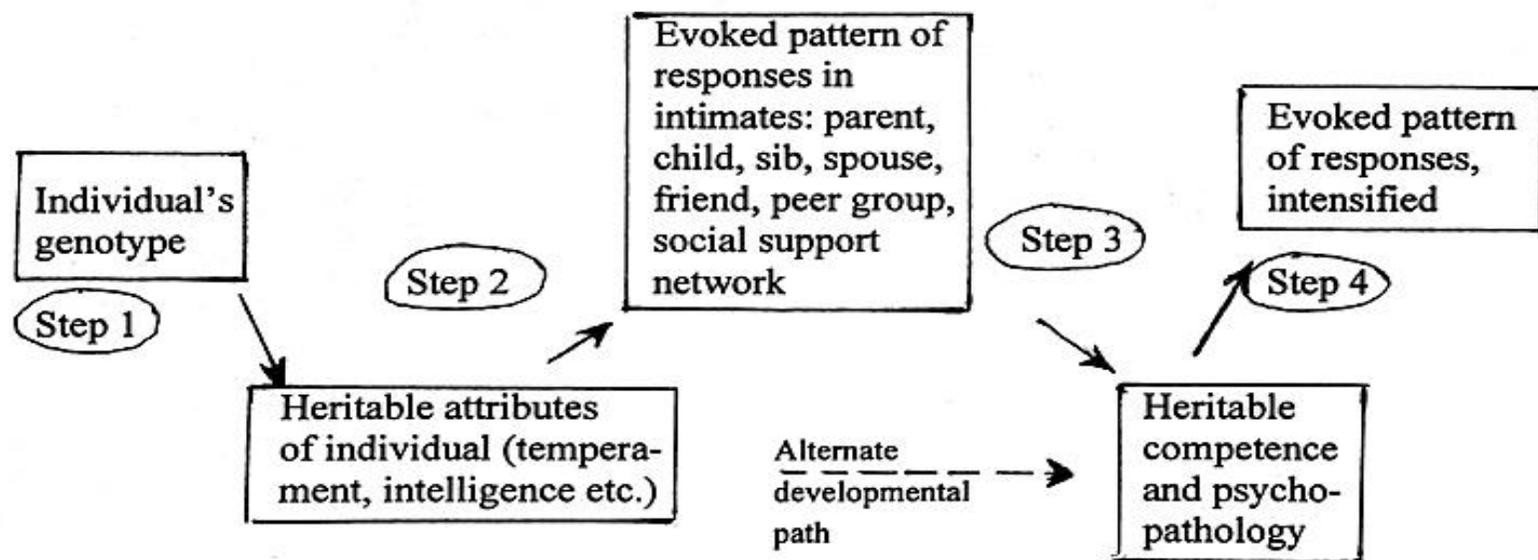
Rationale for Combined Therapy

- 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 increase compliance

Reasons Why Psychotherapy is Important

- Some conditions have no effective treatment
- 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

Figure 1. Reiss' Evocative Model



Reiss D, Pederson NL, Cederblad M, et al. Genetic probes of three theories of maternal attachment: Recent evidence and a model. *Fam Process* 40:247-259, 2001.

Percent Describing Psychotherapy as “Very Important” to Lithium Compliance

- Prescribing physicians (n=50) 27%
- Patients (n=47) 50%

Lasting Characteristics Attributed to Mood Disorders by Bipolar (N=35) and Unipolar (N=35) Patients

- Overall sensitivity BP = UP
- Sexual intensity BP > UP p=0.01
- Productivity BP > UP p=0.001
- Creativity BP > UP p=0.001
- Extroversion/social ease BP > UP p=0.001

Combined Therapy

Effect of New Atypicals

1) ↓ side effects (e.g. EPS), which may
↑ access to psychosocial treatment

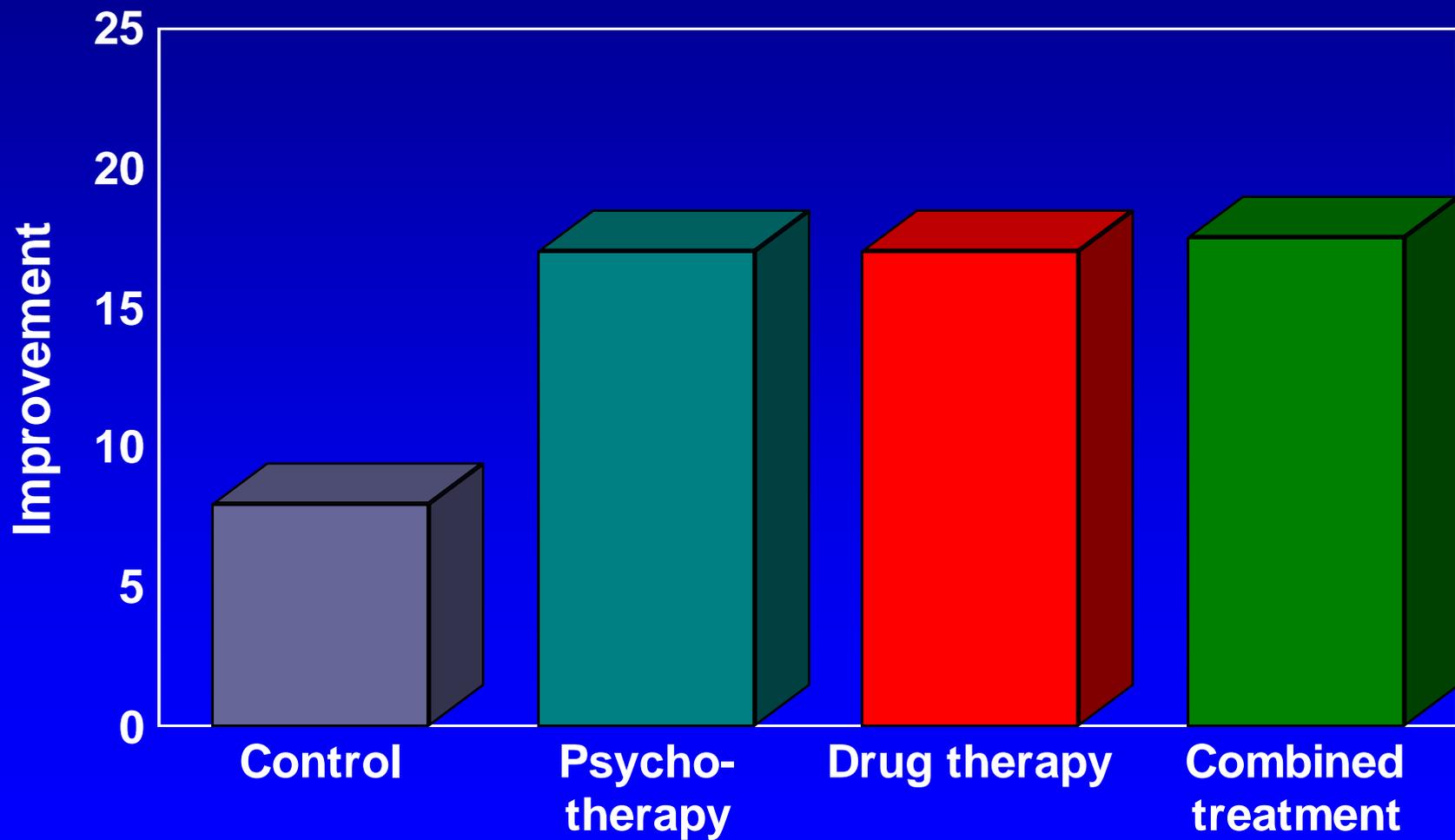
2) Improvement in negative symptoms, which
↑ function and access to psychosocial
treatment and rehabilitation

Outcomes of Combined Treatment

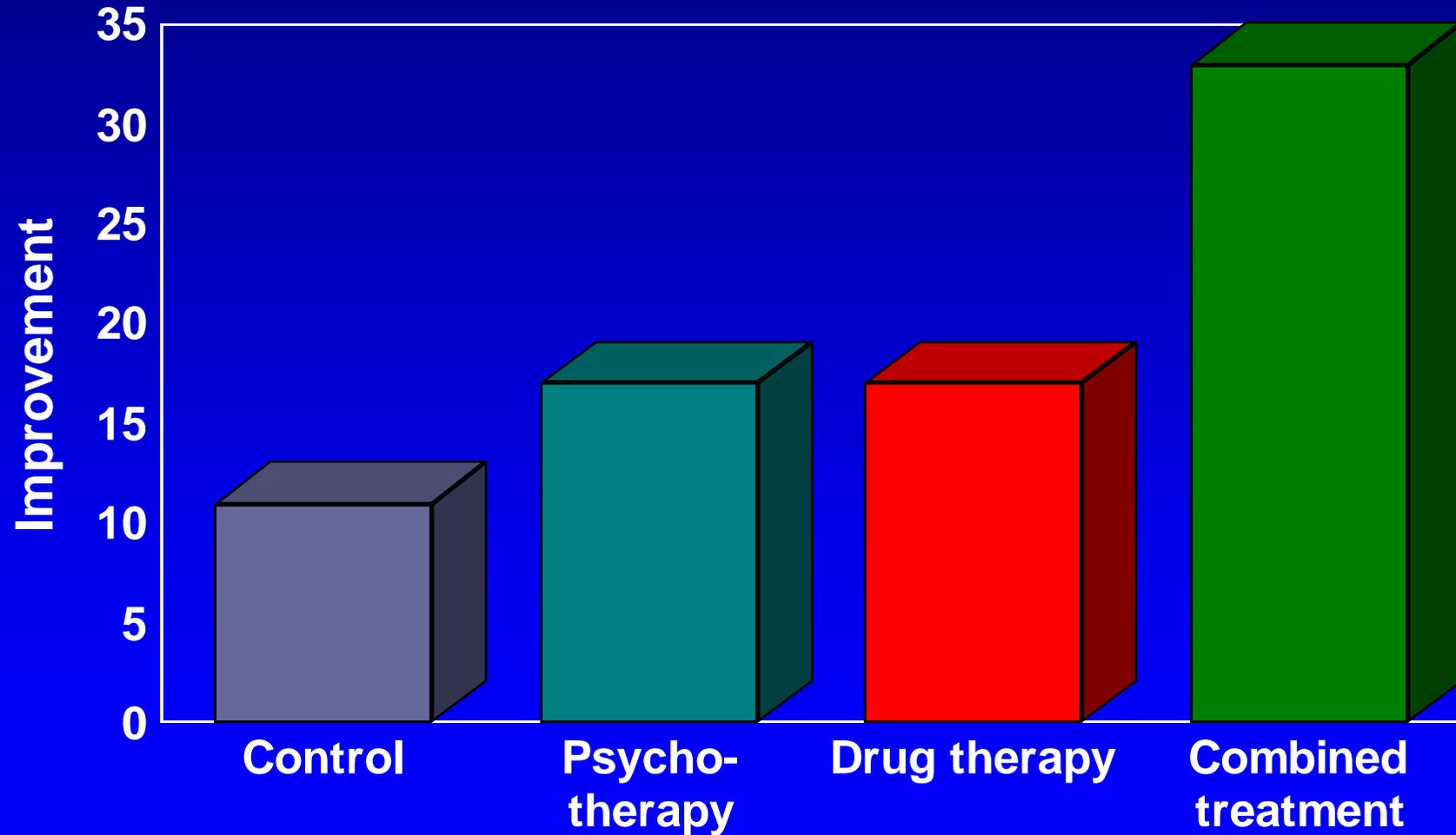
- Positive effects
- Negative effects
- No effect

Combined Treatment Outcome

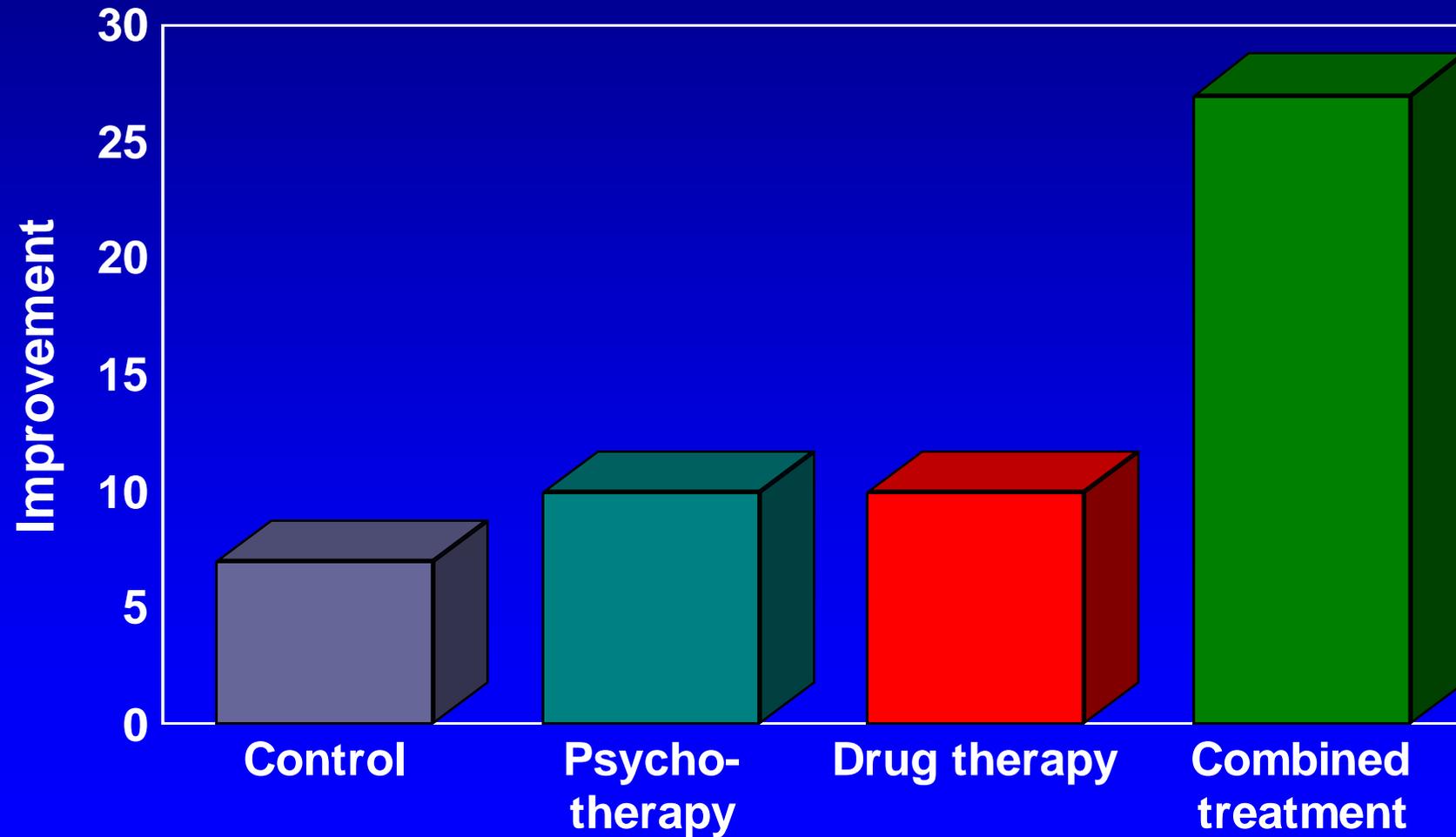
No Additive Therapeutic Effect



Combined Treatment Outcome Positive Effect — Additive

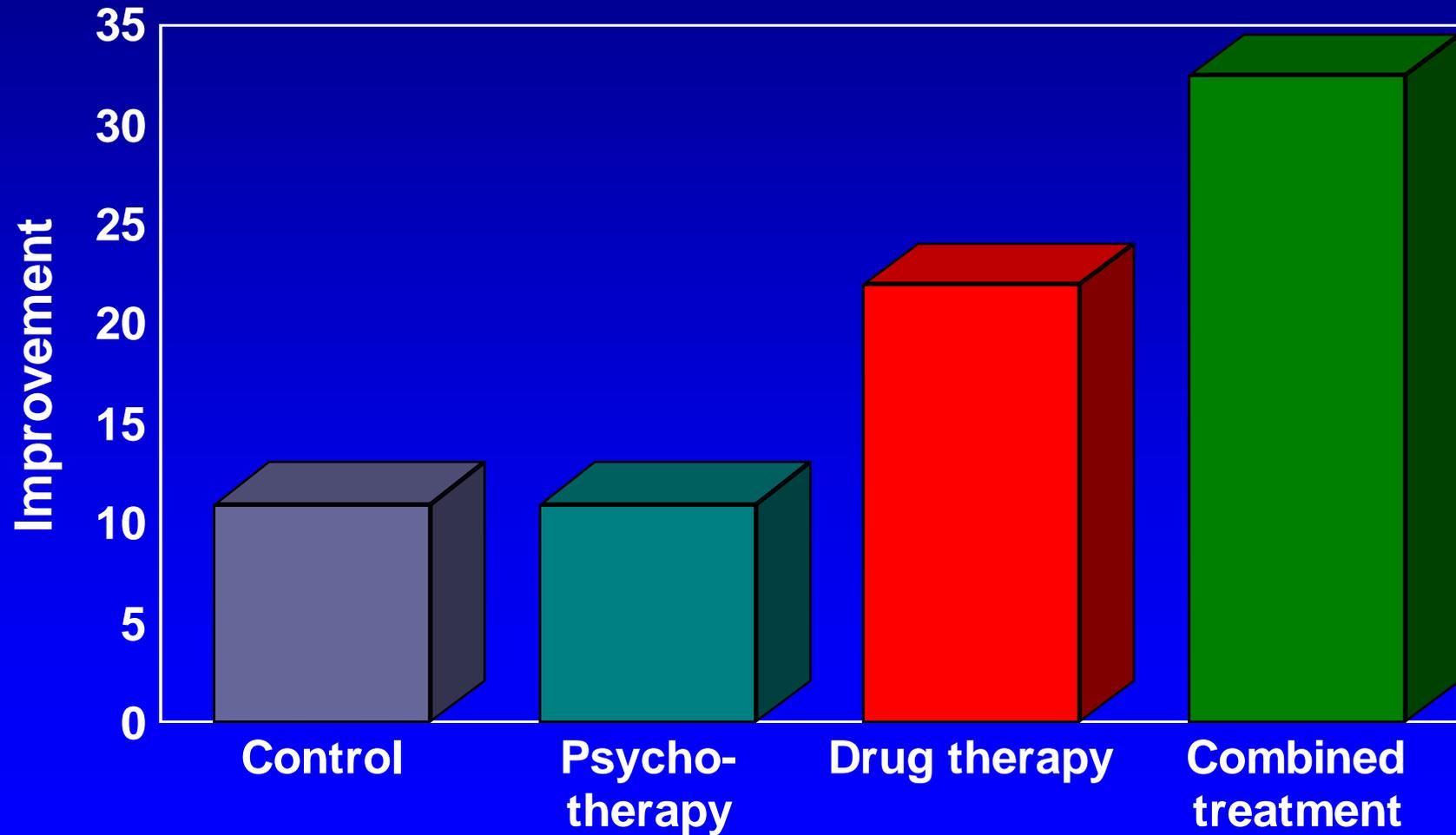


Combined Treatment Outcome Positive Effect — Synergistic

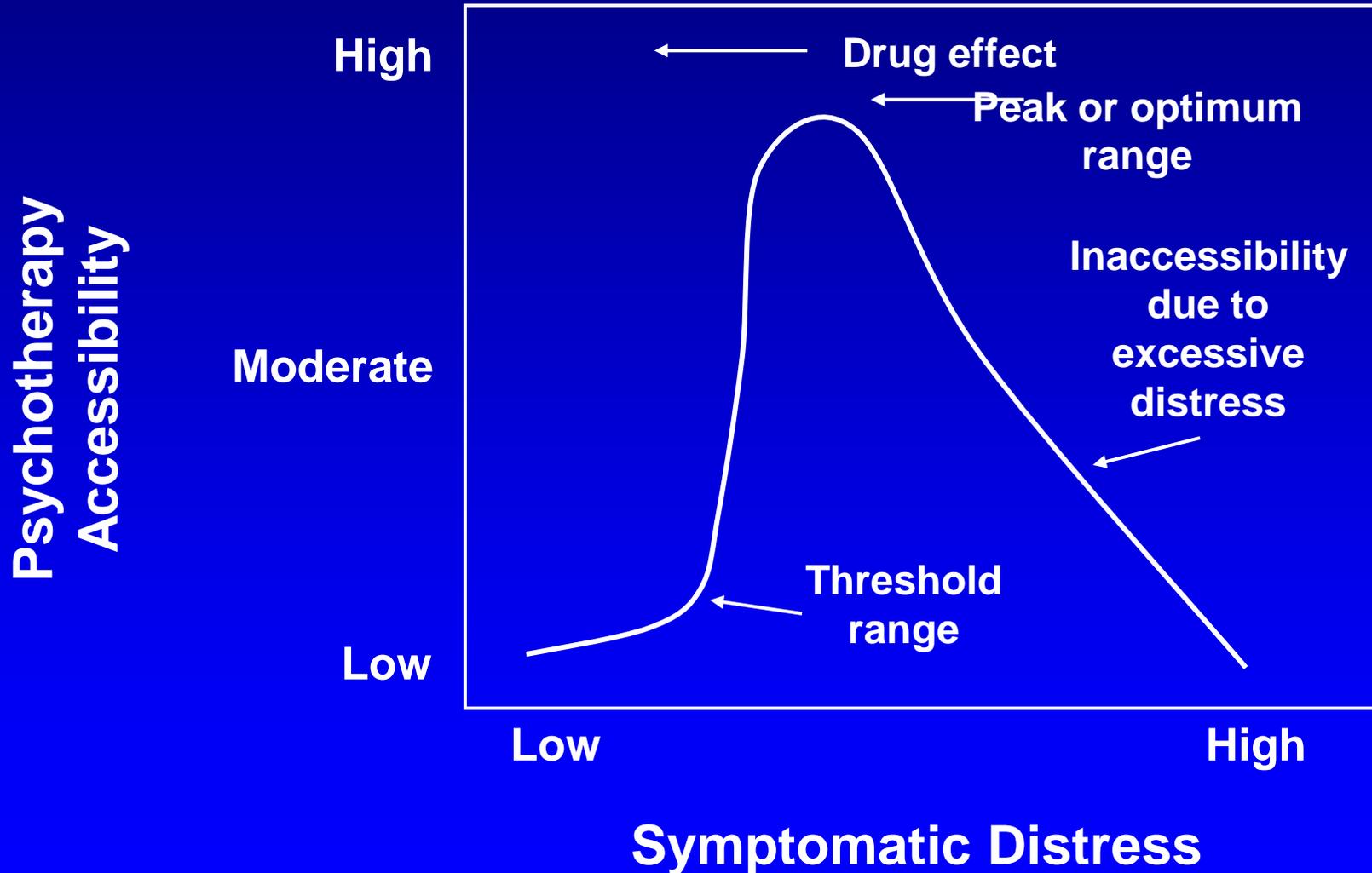


Combined Treatment Outcome

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.

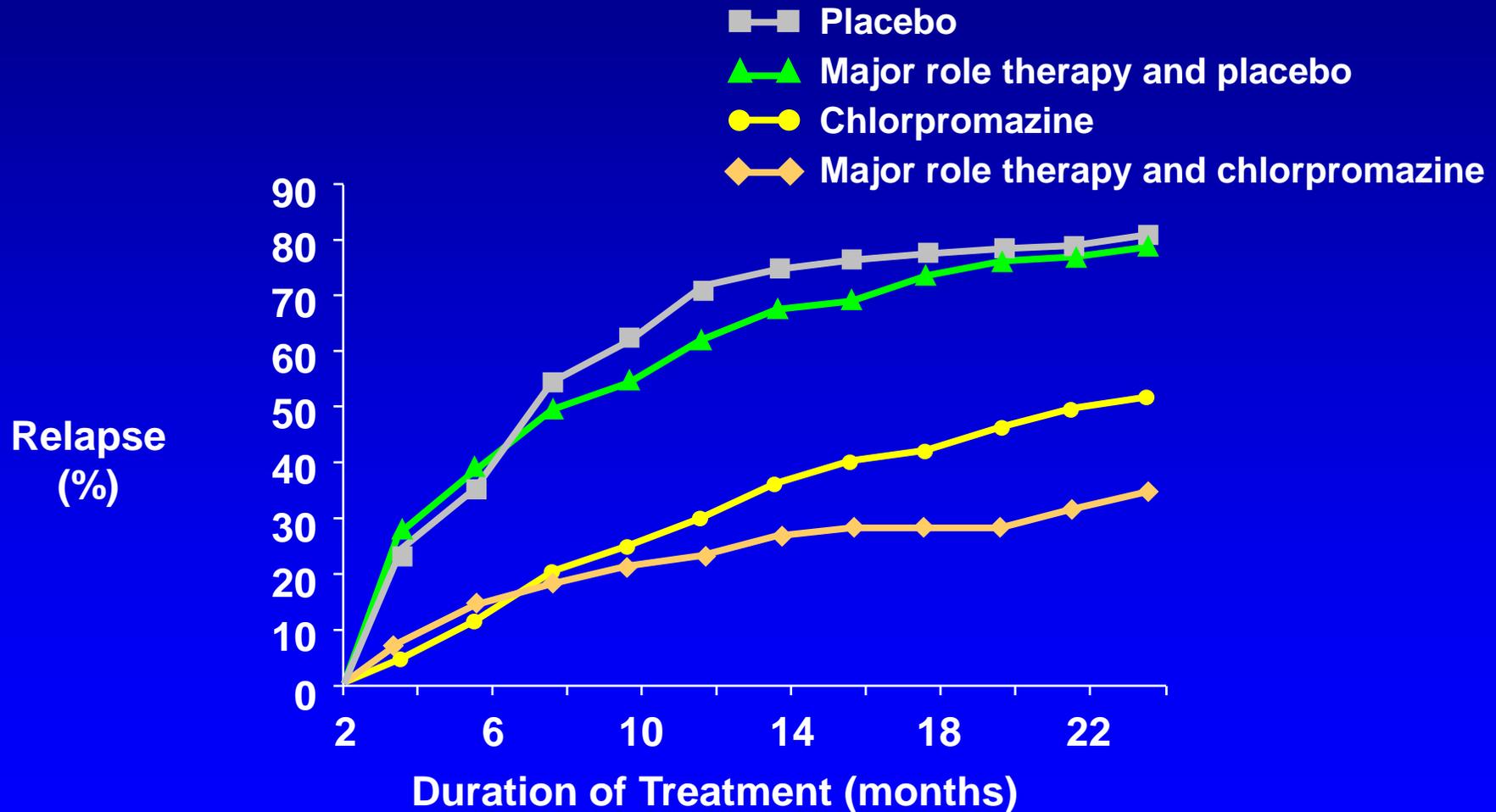
Hogarty GE et al. *Arch Gen Psychiatry*. 1974;31:609-618.

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)

Cumulative Relapse Rates in Schizophrenia



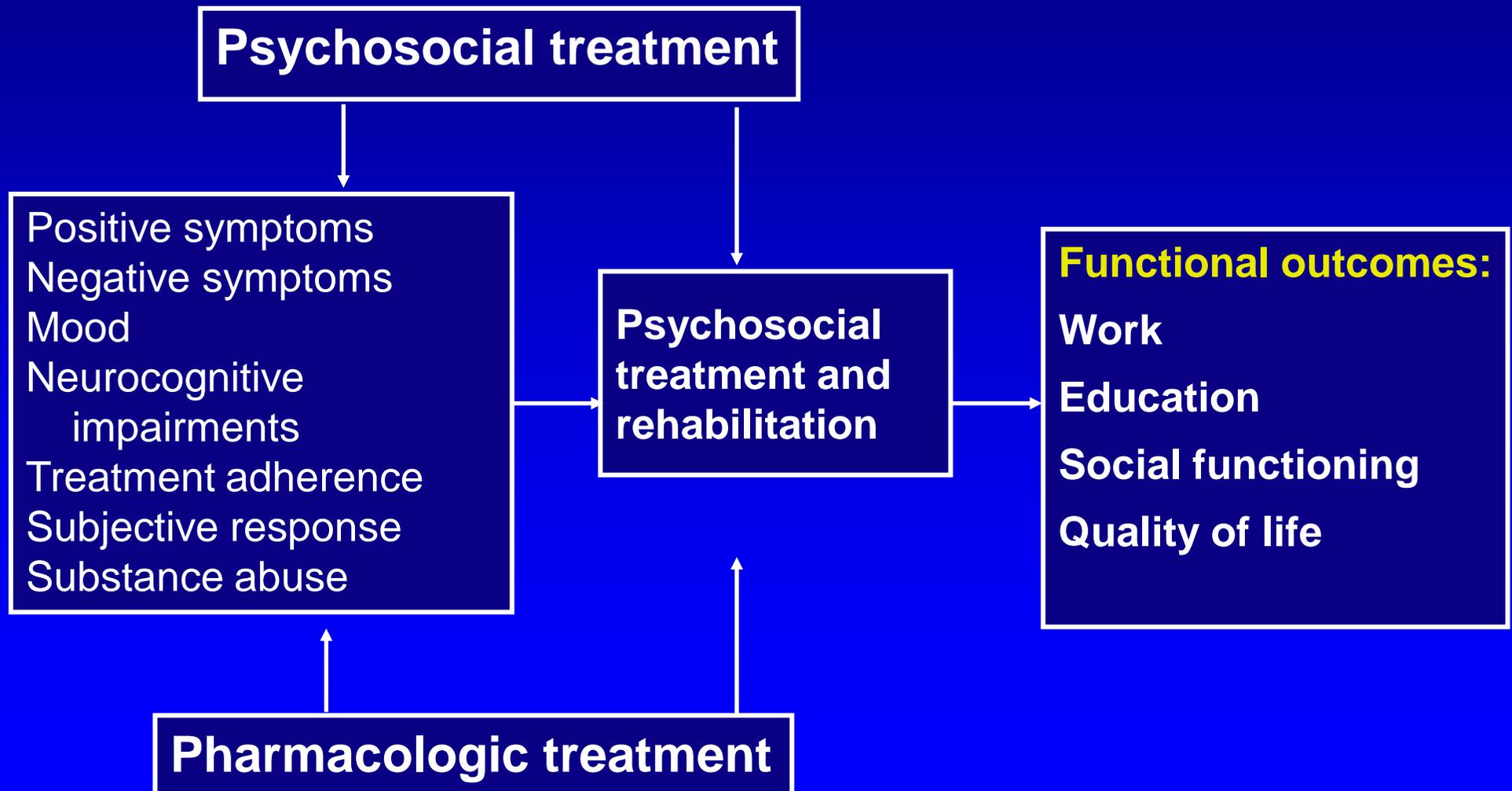
Trials Combining Medication With Psychosocial Treatments (Both Controlled)

	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

Combining Pharmacologic and Psychosocial Intervention



***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 hyperactivity 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 I clinical trial comparing behavioral intervention alone and medication alone with the two together
Major depressive 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 agents

*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

Outline

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

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 lift one’s spirits in response to something savory or encouraging will be found to be the clinical culprits that result from

Practical Guidelines For Combined Therapy

- **Make a DSM IV diagnosis and a family systems diagnosis**
- **Have specific goals for each modality**
- **Be aware of side effects of drug therapy, family psychotherapy, as well as their interaction**
- **When and in what sequence to use each of the modalities**
- **For whom is combined treatment and medication not indicated**

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

Sequencing of Combined Treatments

- Step 1** **Establish alliance**

- Step 2** **Start out on medication,**

 refer family to consumer group

- Step 3** **Begin psychoeducation for family and for patient p.r.n.**

- Step 4** **Begin individual supp. psychotherapy,**

 Begin family supp. intervention

- Step 5** **Family dynamic and systemic intervention**

- Step 6** **Rehabilitation**

Combined Therapy

Structure of Sessions(s)

Part 1 - Psychopharmacology Review

- Global questions
- Review of side effects and target symptoms
(compared to baseline)
- Psychoeducation
- Prescription (now or end of session)

Combined Therapy

Structure of Sessions(s)

Part 2 - Psychotherapy

- Transference - to pill, to therapist
- Countertransference
- Life Events

Combined Therapy

Structure of Sessions(s)

Part 3 - Combined Therapy Integration

- Patient Issues
- Family Issues

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 for non-compliant patients (rather than po)

Medication (Continued):

C. Pharmacotherapeutic Alliance (PA, Gutheil):

- 1. Defined as the manner 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**

Lack of Insight

- Common problem in other conditions
 - Schizophrenia (2/3 of patients have poor or only partial insight)
 - Alzheimer's disease
 - Right parietal stroke syndromes (anosognosia)
 - Bipolar disorder (1/2 have poor or partial insight)

Significance of Insight

- Impaired insight is associated with
 - Poor medication compliance (most common cause of noncompliance in mania: 26%)
- Poor prognosis in schizophrenia and bipolar disorder
- Cognitive impairment (frontal function)
- Poor therapeutic alliance

Insight and Typical Neuroleptics

- Despite improvement in acute psychopathology, insight did not improve acutely with typical neuroleptics (in schizophrenia or mania, 1 month of treatment)
- Typical neuroleptics did not improve cognitive function in schizophrenia despite resolution of acute psychosis

Insight and Suicide

- Usually, increased insight into negative symptoms is associated with overall increased risk of suicide
- Sometimes, improved insight can be associated with demoralization after an “awakening” experience
- Careful psychotherapeutic attention is required

Amador XF et al. *Am J Psychiatry*. 1996;153:1185-1188.

Lindstrom LH. *Acta Psychiatrica Scand*. 1994;380(suppl):74-76.

Summary

- Enhancing compliance depends on improving subjective aspects of medication effects
 - Weight gain: quality of life and mortality
 - Akathisia: underrecognized, common with all atypical agents, crucial for compliance, minimize dose
- Insight: key long-term prognostic factor, another important advantage of atypicals

Psychotherapy: → Psychiatric Management

- A. Defined as the whole range of services including medical, supportive, psychosocial and rehabilitation strategies**
- B. Rationale: No psychosocial strategy by itself can change life course for schizophrenia**
- C. Which type and which phase - family intervention (rather than individual) in acute phases
Family combined with individual therapy in maintenance phases**
- D. Which model - psychoeducational (rather than psychodynamic or cognitive)**
- E. Psychotherapeutic alliance - characterized by receptive, open stance**
- F. How long and how much - (long-term and as needed)**
- G. Patient as partner on the treatment team**

Seven Components of Effective Family Approaches to Schizophrenia

(Lam)

- 1) Offer a positive approach and genuine working relationship between the therapist and family.**
- 2) Provide family therapy in a stable, structured format with the availability of additional contacts with therapists if necessary.**
- 3) Focus on improving stress and coping in the “here and now,” rather than dwelling on the past.**

Seven Components of Effective Family Approaches to Schizophrenia

(Lam)

- 4) Encouragement of respect for interpersonal boundaries within the family.**
- 5) Provide information about the biological nature of schizophrenia in order to reduce blaming of the patient and family guilt.**
- 6) Use behavioral techniques, such as breaking down goals into manageable steps.**
- 7) Improve 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**

Individual Intervention

- **To form an alliance**
- **To maintain self-esteem**
- **To maximize compliance**
- **To diagnose and manage**
 - **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 hysterical."
- 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.

Psychoeducation - Who Does It?

- **Psychiatrist**
- **Social Worker**
- **Rehabilitation Therapist**
- **Nurse**
- **Consumer Organizations**

WORTH A THOUSAND WORDS



1998



2002

PEKIN, Ill. — Former methamphetamines addict Penny Wood avoided a prison term by agreeing to let Illinois State Authorities use these before-and-after pictures of her in order to steer people away from drug use. She now regrets the deal, saying that the pictures are an embarrassment to her, her children and grandchildren. AP PHOTO

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

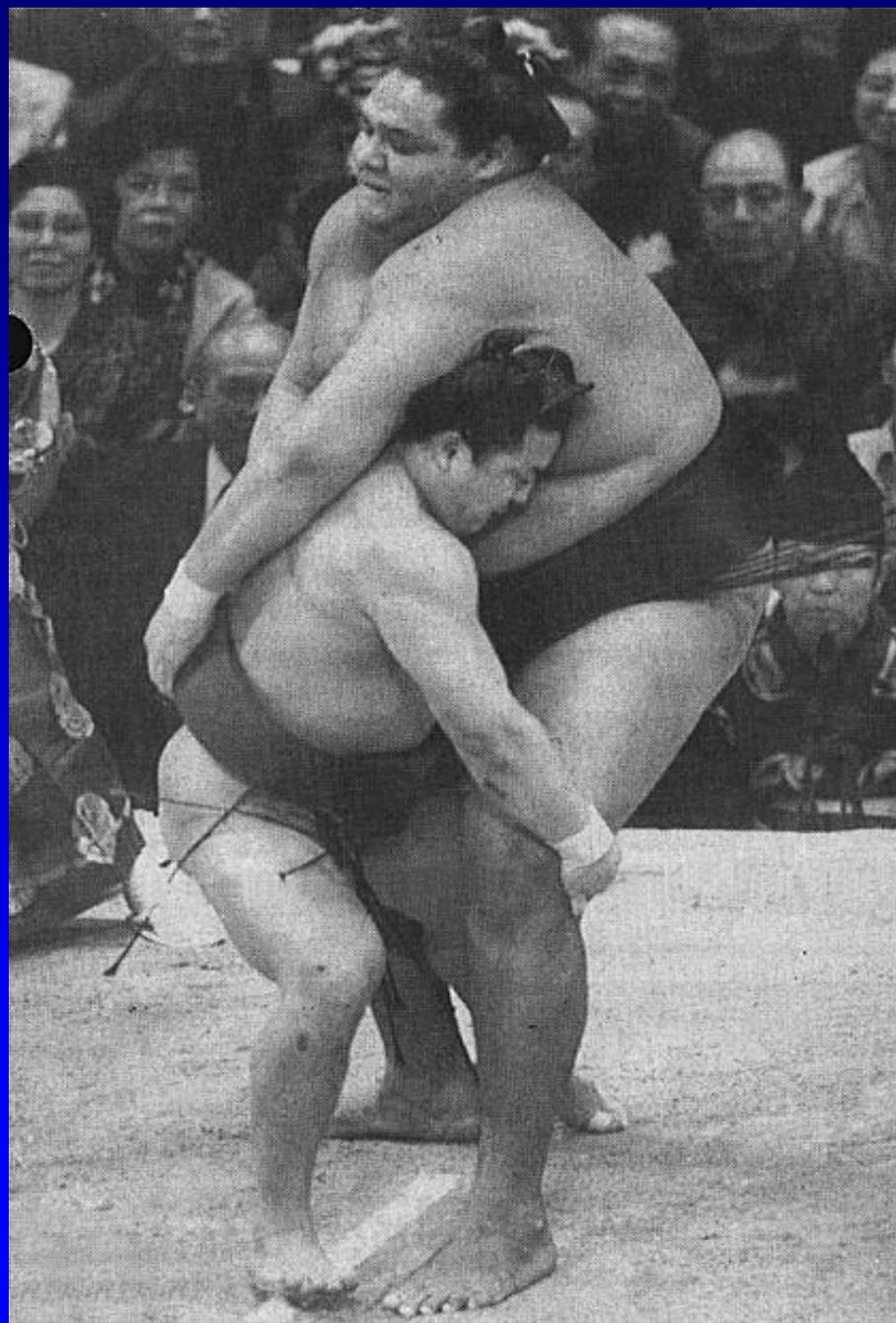
Combined Therapy

Disadvantages

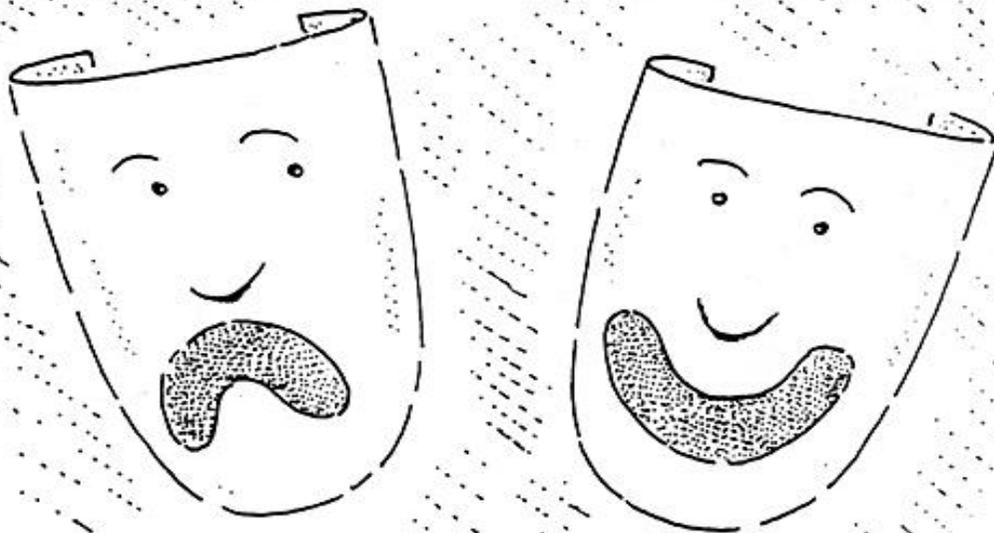
- 1) With medication, ↑ risk for side effects and early termination of all therapies
- 2) With psychotherapy, perceived need for medication decreased (“I can solve this on my own”)

Outline

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

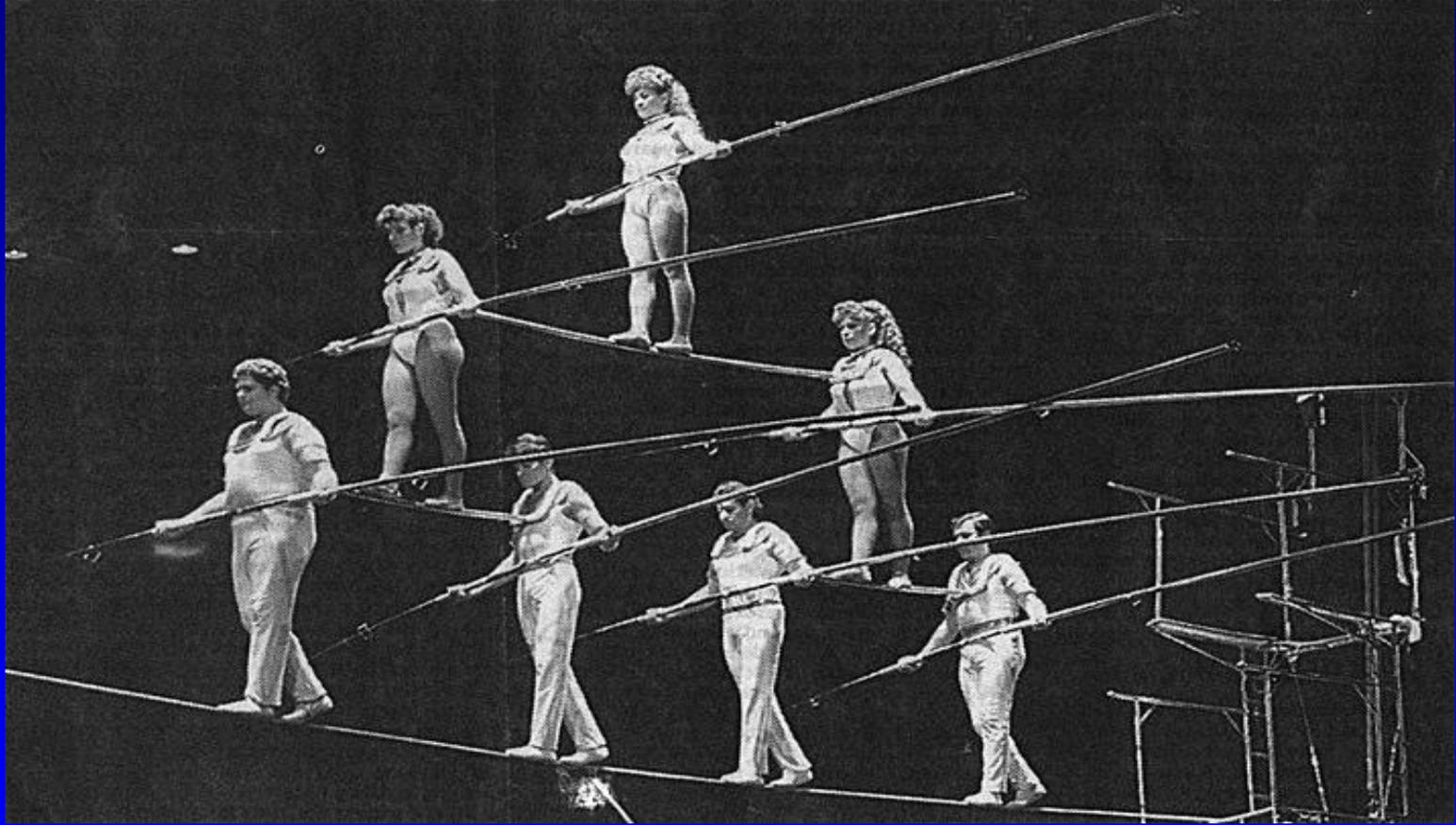


The New Yorker 1992



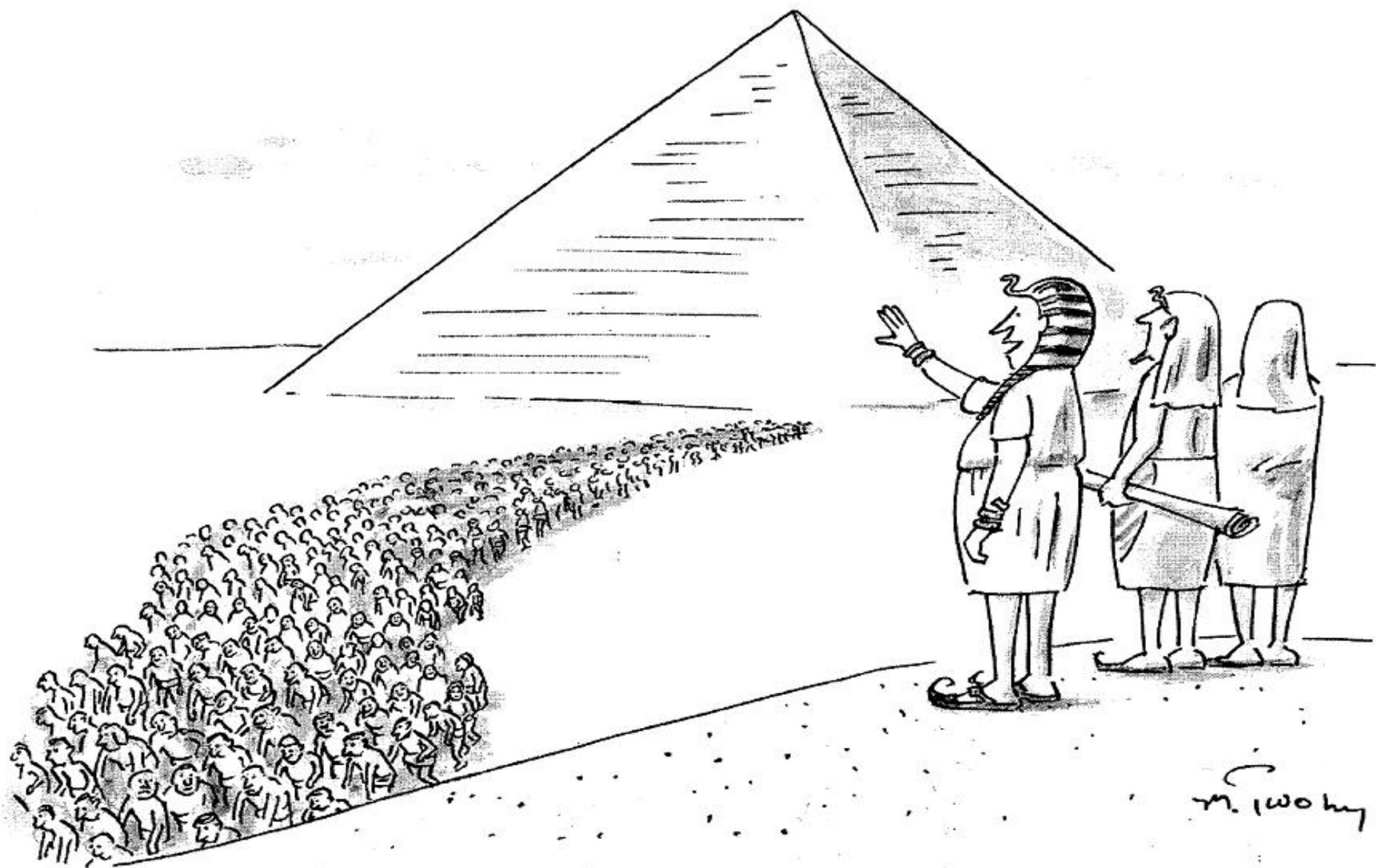
MANKOFF

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



Remaining Issues

- Ethical
- Legal
- Financial
- Primary Care



"Thanks, guys. Looks great!"

Discussion

Emilio is a 30-year-old male brought to the hospital for his 12th hospitalization by his 52-year-old mother because she is afraid of him. He is dressed in a ragged overcoat, bedroom slippers, and a baseball cap, and wears several medals around his neck. His affect ranges from anger at his mother, “she feed me shit...what comes out of other people’s rectums”, to a giggling, obsequious seductiveness toward the interviewer. His speech and manner have a childlike quality, and he walks with a mincing step and exaggerated hip movements. His mother reports that he stopped taking his medication about a month ago, and has since begun to hear voices and to look and act more bizarrely. When asked what he has been doing, he says, “Eating wires and lighting fires.” His spontaneous speech is often incoherent and marked by frequent rhyming and clang associations. Emilio’s first hospitalization occurred after he dropped out of school at age 16. Prior to his first onset of symptoms, his mother and father had divorced with much residual hostility. Since that time, he has never been able to attend school or hold a job. He lives with his mother, but sometimes disappears for several months at a time and is eventually picked up by the police as he wanders in the streets. There is no known history of alcohol or drug abuse. His admission laboratory profile and drug screen are normal.

Questions for discussion

Discuss Emilio's multiaxial diagnosis.

1. If Emilio refused an oral antipsychotic, what are the guidelines for administering forced or parenteral antipsychotics? How could the family be helpful in this regard?
2. What should you inform the patient and family about side effects? How is this related to compliance?
3. Discuss the guidelines for combining pharmacologic and nonpharmacologic therapies.
4. What types of nonpharmacologic strategies are appropriate for acute versus maintenance phases?
5. What model (psychoeducational, psychodynamic, or cognitive) is optimal?

Discuss psychoeducational strategics for patients and family members.

1. How would you respond to the statements, “Am I crazy”, “Is it my fault”, “Can it affect my children?”
2. What are the components of family intervention? In the initial family assessment, what questions would you generally ask? What consumer groups would you refer caregivers to?
3. Is combination therapy appropriate for Emilio, and if so, what strategics would you use?

Review of his prior records revealed a diagnosis of chronic schizophrenia, disorganized type. His most recent medication regimen was 10 mg of haloperidol daily. Emilio was generally compliant with medication, though he episodically stops the haloperidol because he is ashamed and stigmatized by the thought that he has to take a drug for a mental illness. His mother reports that while on medication, he is aloof and does not participate in social activities, choosing instead to listen to a headset radio. His mother continues to feel that her problems with Emilio are all the fault of her ex-husband (Emilio's father), which gave her this son. She states she is "tired" of caring for Emilio and would like to find an alternative living/caring situation for him.

Questions for discussion

4. Would you choose psychoeducation or individual therapy to enhance compliance?
What is case management?
5. What patient and consumer support groups would you refer the mother to? What is NAMI?

After Emilio's symptoms were controlled by these initial strategies, he expresses a desire to obtain a job as a clerk. He has previously held a similar job for a brief period that he says he found satisfying.

6. Discuss vocational and social skill rehabilitation strategies.