

Combining Pharmacotherapy with Psychotherapeutic Management for the Treatment of Psychiatric Disorders

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Characteristics of Psychotherapy Received in U.S.

	<u>1987</u>	<u>1997</u>	
Psychotherapy >20 visits	16%	10%	P< .004
Any psychotropic medication received	32%	62%	P< .0001

Olfson, 2002



Issue

What does psychotherapy add above what medication alone provides?:

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



Outline

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

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

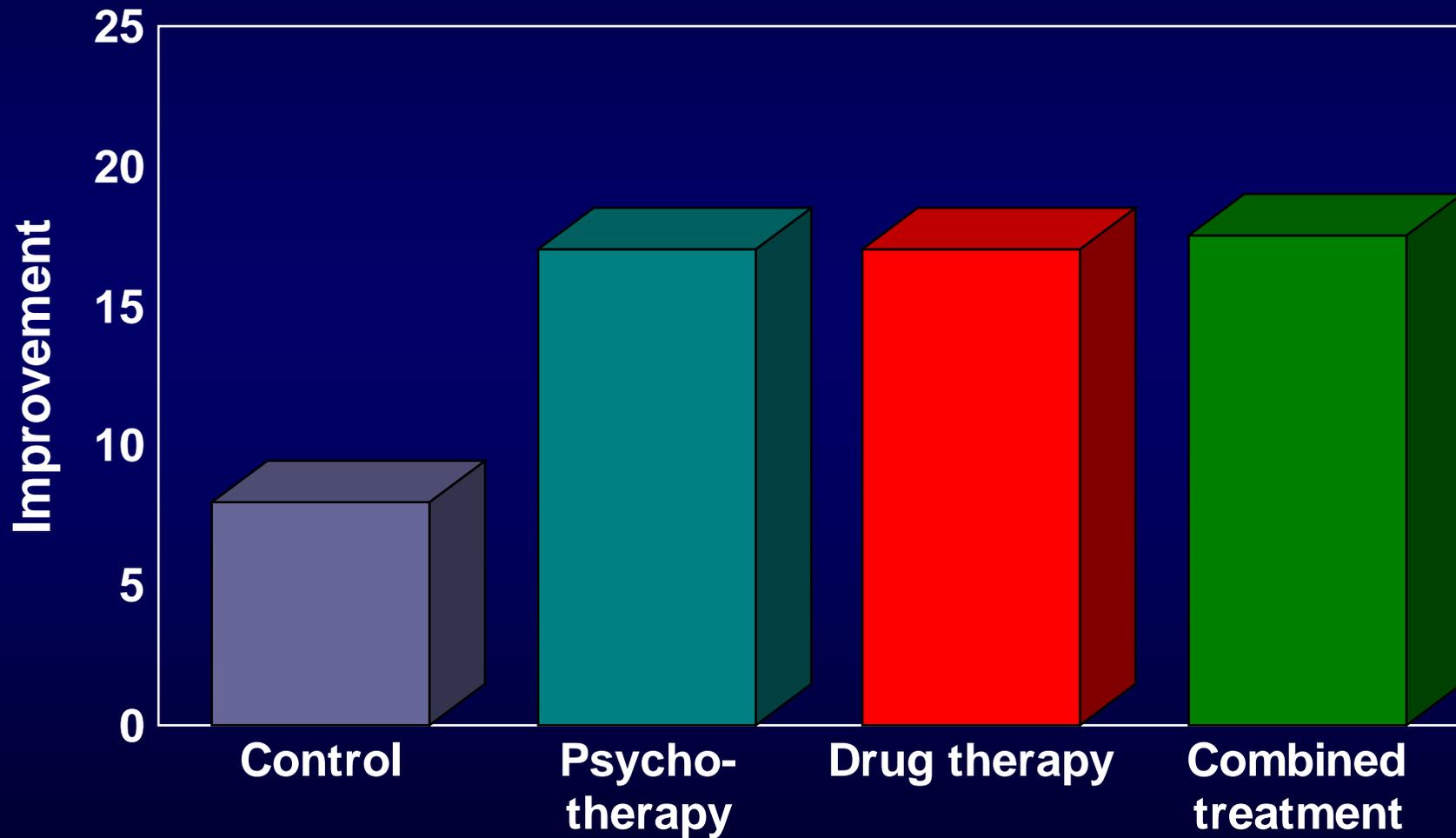
- Some conditions have no effective treatment
- Medication may be contraindicated
- Patient may not want to take medication (numerous reasons)
- Most patients have social and interpersonal problem accompanying Axis I disorders either as the source of or are the consequence of the illness

Outcomes of Combined Treatment

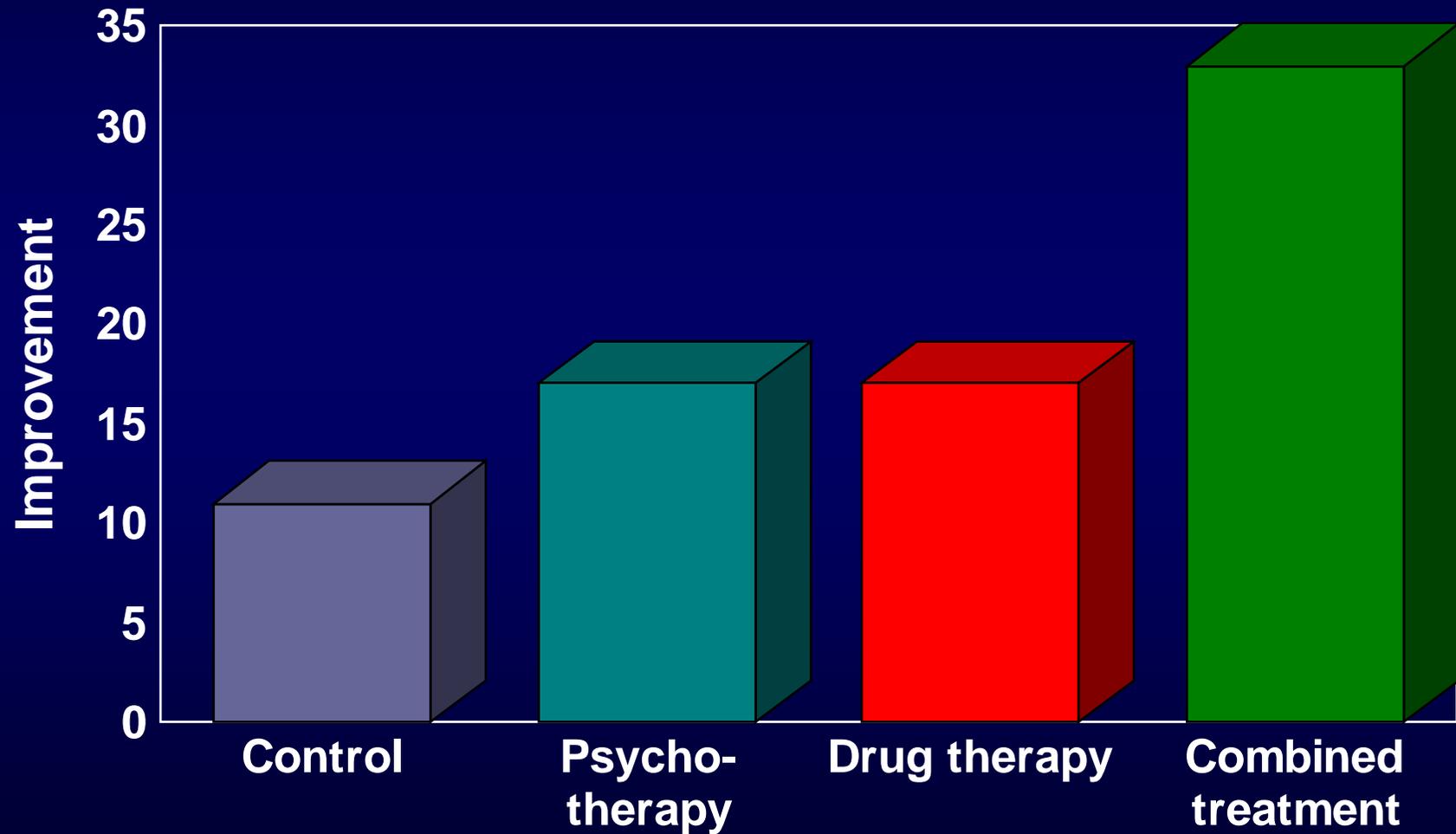
- Positive effects
- Negative effects
- No effect

Combined Treatment Outcome

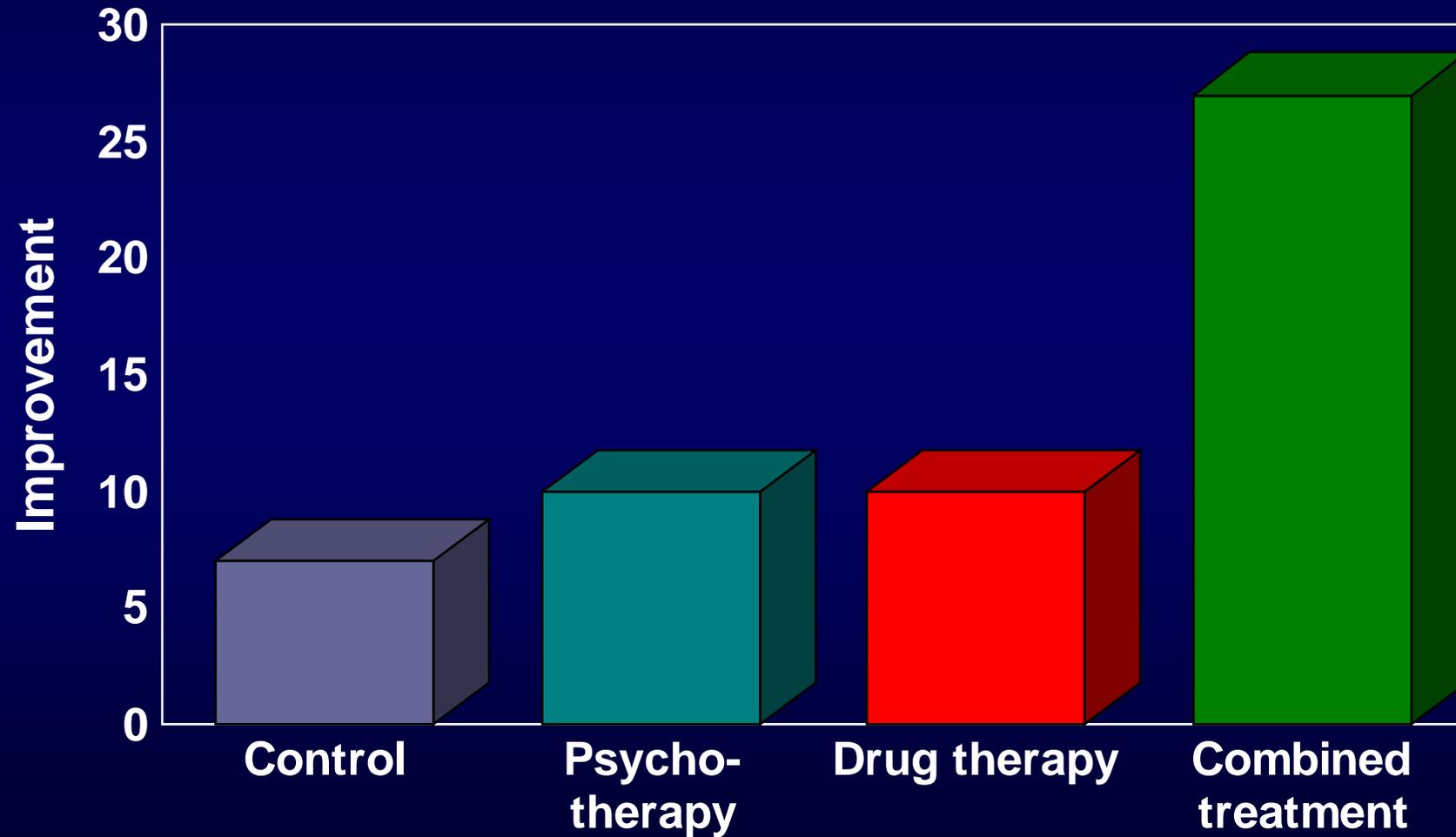
No Additive Therapeutic Effect



Combined Treatment Outcome Positive Effect — Additive

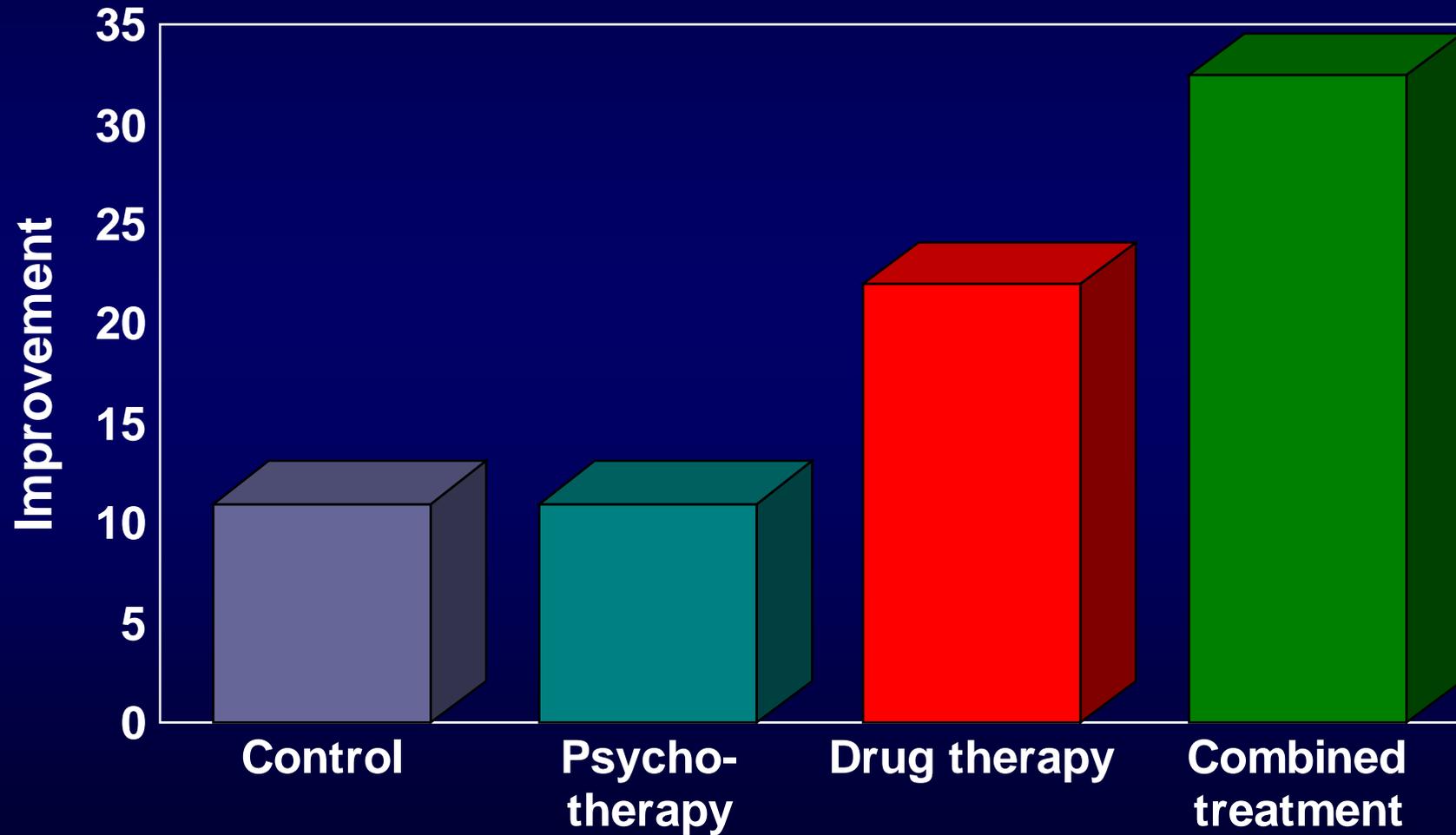


Combined Treatment Outcome Positive Effect — Synergistic

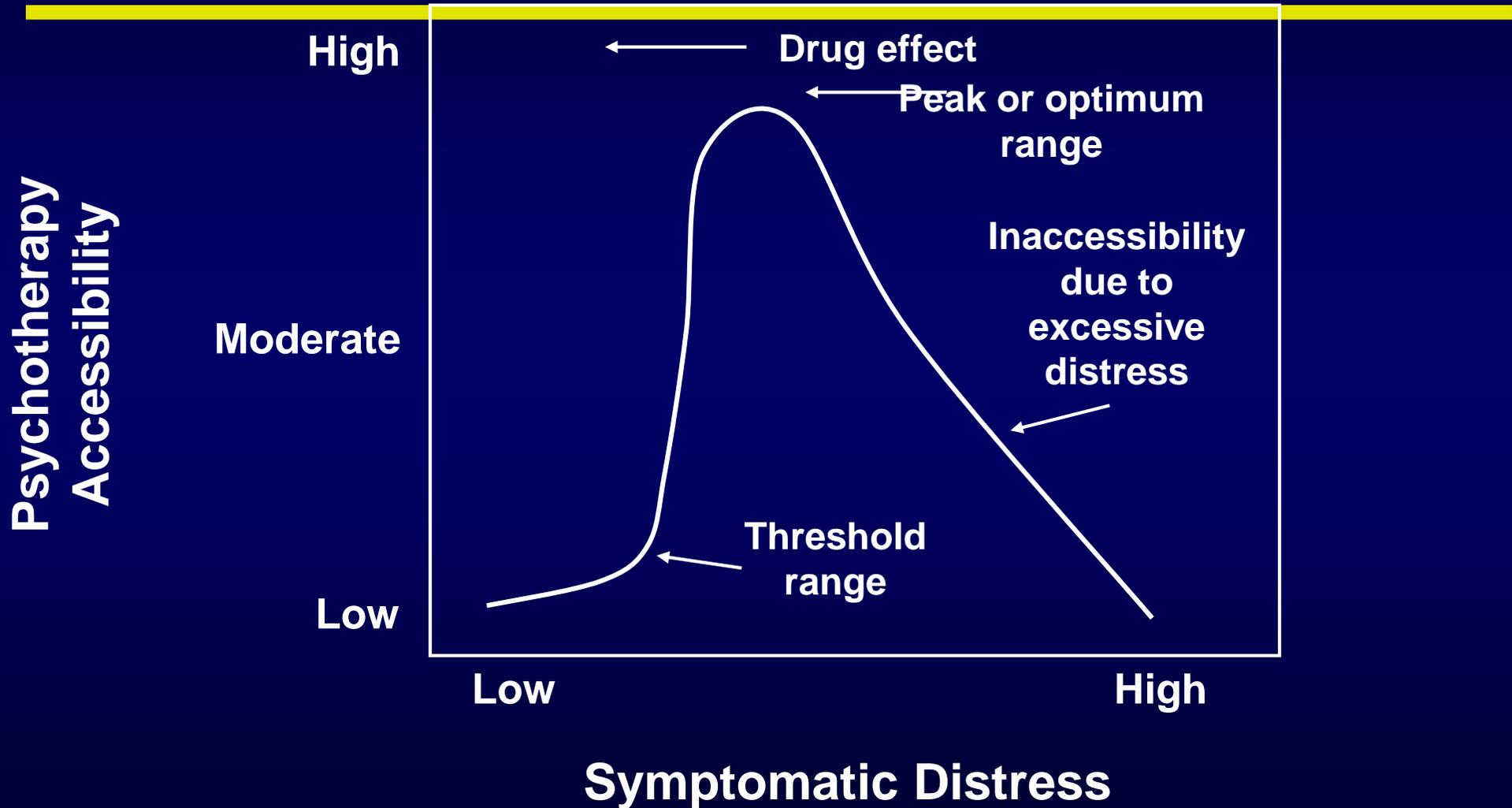


Combined Treatment Outcome

Positive Effect — Facilitative



Medications Facilitate Accessibility to Psychotherapy



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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)



***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

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

Disorder/Syndrome	Treatments	Standard of Proof
Bulemia Nervosa (BN)		<ul style="list-style-type: none"> • 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

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Combining Pharmacologic and Psychosocial Intervention

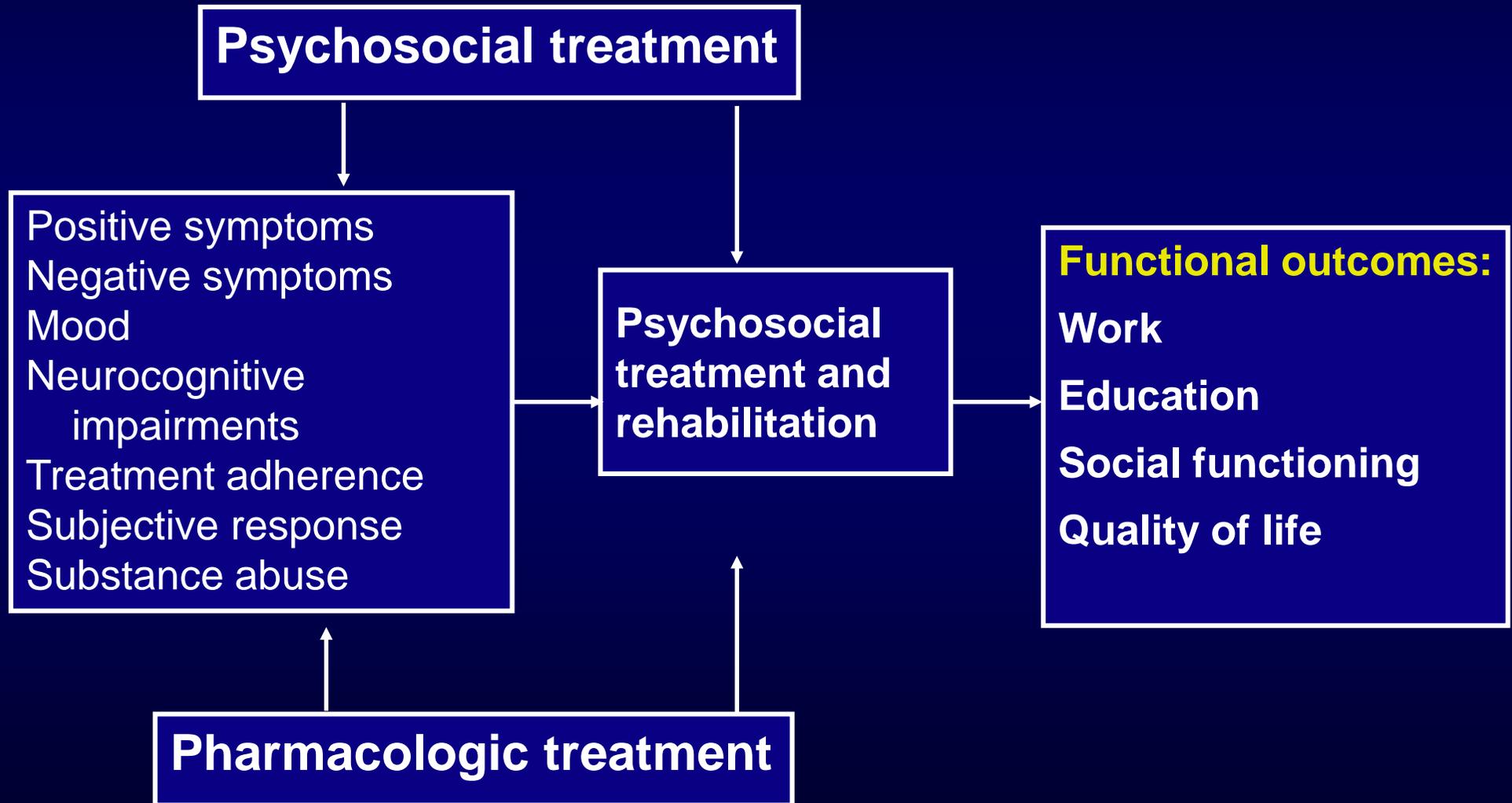


Table 1 - General Guidelines for Combined Therapy:

I - Diagnosis

- Make a DSM-IV diagnosis
- Make a family systems diagnosis
- Make an individual dynamic diagnosis



Table 2 - General Guidelines for Combined Therapy:

II - Goals

- Develop specific goals for each modality
- 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



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



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 a 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



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 5 - General Guidelines for Psychotherapy

- Which type in which phase
- Which model in which phase - provide psychoeducation early then psychodynamic or CBT, and/or family systemic intervention, as patient and family can utilize it
- Psychotherapeutic alliance characterized by receptive and “open stance”
- Duration - varied but can be intermittent as needed over lifetime of illness
- Approach - patient and family viewed as partners on “treatment team”

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



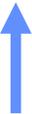
Table 8 - Psychoeducation for Combined Treatment

- 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



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

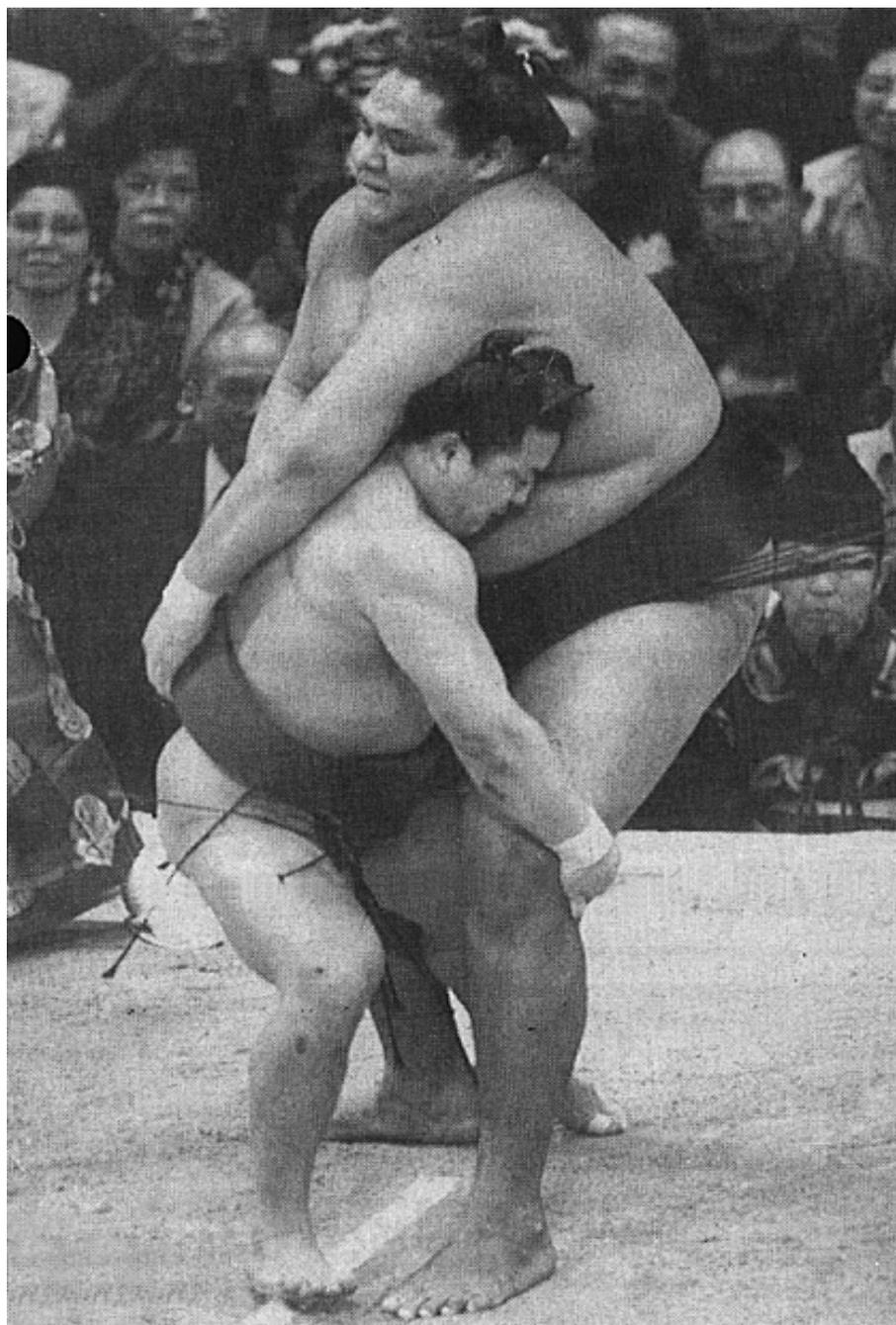
Combined Therapy

Disadvantages

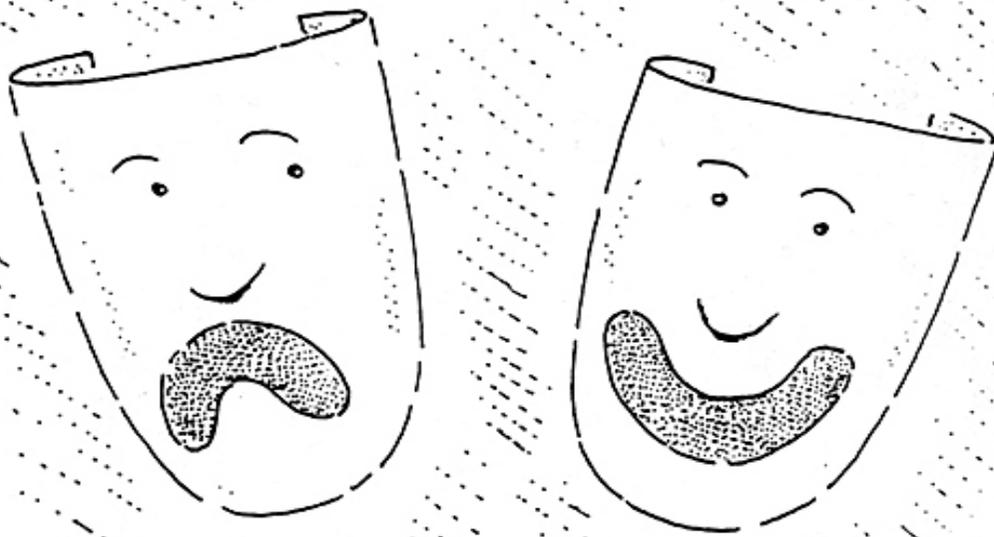
- 1) With medication, ↑ risk for side effects and early termination of all therapies
- 2) With psychotherapy, perceived need for medication decreased (“I can solve this on my own”)

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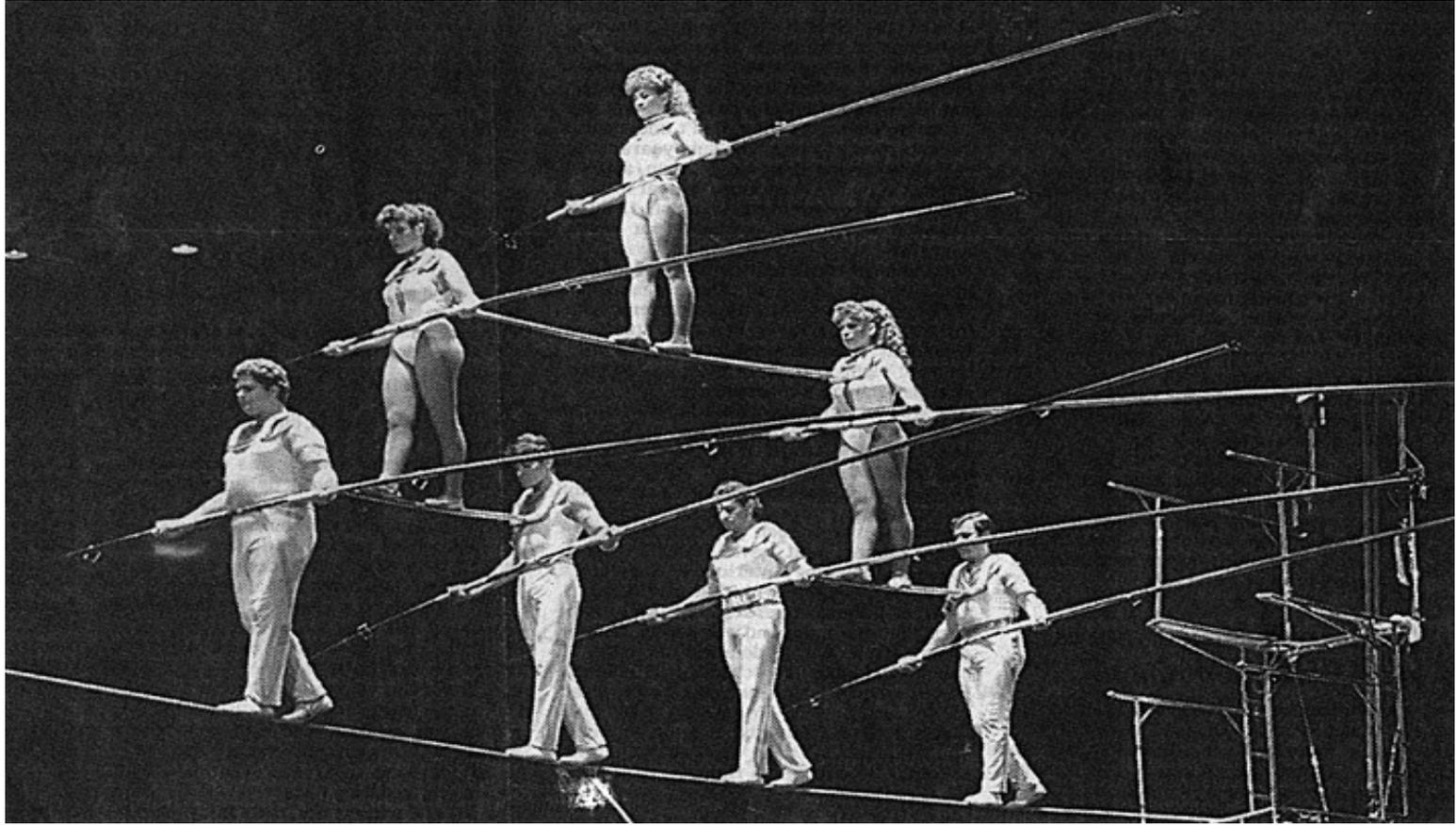


The New Yorker 1992



MANKOFF

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



Quality Treatment Equation

Quality Treatment = **Medication** + **Family Intervention** + **Individual Intervention** + **Customer Group Support**

What We Know

- Psychotherapy added to medication can improve outcome more than medication alone
- For some disorders, for some patients at some phases of their illness
- Especially to insulate against relapse



What We Don't Know

- Which type of psychotherapeutic intervention?
- In what dose? What duration?
- Delivered by whom?

