Combining Psychotherapy and Drug Treatment:
Does it Change the Process of Psychotherapy?

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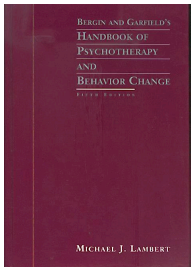
I never received one single penny from industry; all my money came from official research institutions like DFG

1

Ample Evidence



- Focused psychosocial interventions have significant benefit when added to pharmacotherapy of patients with a number of persistent and severe mental disorders.
- Thase M & Jindal R (2004) Combining psychotherapy and pharmacotherapy. in Lambert MJ (Ed) Bergin and Garfield´s Handbook of Psychotherapy and Behavior Change. New York Chichester Brisbane Wiley pp 743-766

2

Best established:

- schizophrenia;
- severe, recurrent, and chronic depressive disorder;
- obsessive-compulsive disorder;
- bipolar affective disorder;
- *Less so:*
- bulimia
- panic disorder

3

Effects: Domain or Disorder

- some effects are domain-focused
  (expressed emotions)
- other effects are disorder-focused
  (social skill training)

4

No Routine

- There is **no evidence** that psychotherapy-pharmacotherapy combinations should be routine standard of care for less pervasive or milder depressive and anxiety disorder.

5

Negative Impact

- Is there a debate on negative impact of psychotherapy on pharmacotherapy?
- Not that I am aware of!

6

Positive Impact

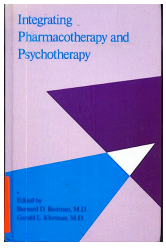
Is there any positive impact of psychotherapy on pharmacotherapy?

Apart form the EBM statements I mentioned at the outset

there is wide agreement that a major function of psychological interventions added to pharmacotherapy is directed on the **issue of compliance.**

7

Integration: The P-P Triangle



- The **P-P triangle** consists of three parties:
- The prescribing psychiatrist and the psychotherapist should both reflect the biological and psychological power of the medication.

- Chiles et al. A physician, a nonmedical psychotherapist, and a patient. The pharmacotherapy-psychotherapy triangle.
- In Beitman B, Klerman GL (Eds) (1991) Integrating Pharmacotherapy and Psychotherapy. American Psychiatric Press, Washington, DC, pp 105-118

8

Two-Illness Model

Mrs S: Zoloft has worked for me. This must mean that my symptoms are biological.....

Th: I´m pleased you are feeling better now; still I like to better understand how you interpret your improvement, given all the turmoil you were in before coming to see me

Mrs S: Well, that´s what I am thinking: Why am I here, it was the panic attacks that brought me to see you

Th: I think you may be frightened to consider that your symptoms were also linked to your confusion about whether to marry a man you felt was abusive..

- Busch & Sandberg (2007, p. 53)

9

Synergistic Effects a

- **Medication** can aid psychotherapy not only by reducing disruptive symptoms,
- but also through presenting opportunies to address psychological factors and conflicts triggered through the employment of psychopharmacology.

10

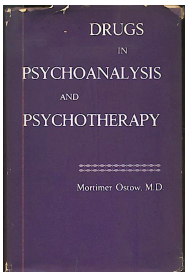
Synergistic Effects b

- **Psychotherapy** can help to relieve patients of several possible adverse reactions to medication, f.e.

- discomfort with side effects,
- conflicts around assertiveness,
- struggles with authority,
- and feelings of shame.

11

Psychodynamic Psychopharmacology



On contrast to early psychoanalytic warnings of medication undermining the patient´s curiosity for psychological processes, a new era **of Psychodynamic Psychopharmacology** has been initiated by M. Ostow s (1962) book.

Ostow M (1962) Drugs in Psychoanalysis and Psychotherapy. Basic Books, New York

Busch F, Sandberg L (2007) Psychotherapy and Medication. The Challenge of Integration. New York - London, Routledge

Mintz D (2011 / September) Psychodynamic Psychopharmacology. Addressing the Underlying Causes of Treatment Resistance. Psychiatric Times, p. 22-24

12

Psychodynamic Perspectives on Psychopharmacology

What appears to be the single most important factor determining pharmacotherapy outcome is a **positive therapeutic alliance**,

and what most contributes to that is the psychiatrist´s attention to **psychodynamic factors** such as the nature of the transference to both the doctor and the medication, conscious or unconscious preconceptions about medications, resistance to giving up symptom that serve defensive or self-serving purposes, and therapist´s **countertranstransference** to the patient´s character style.

13

Competency in Combining

The clinician should be constantly aware of the **seduction of marketing**.

Psychodynamic formulation are not a luxury but are necessary for making **treatment choices** and for evaluating and reevaluating drug choice and the effectiveness of combined treatment.

Psychiatrists should not be intimidated by **time pressure**, especially in early appointments.

Discussions of **chemical imbalance** are generally less helpful than many clinicians think, because it is so difficult to predict what they will mean to any given patient.

14

Competency in Combining

- # The clinician should neither **oversell nor undersell** any one drug as part of the treatment regimes but should instead tell the patient that there are other choices.
- # Psychiatrists should treat their patients as though the **therapeutic relationship** matters more than the pills – because it usually does
-
- Riba M& Balon R (2005) Competency in Combining Pharmacotherapy and Psychotherapy: Integrated and Split Treatment. Washington, DC, American Psychiatric Publishing, p. 107
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15

Does it Change the Process

- It should change the process; psychotherapy routinely delivered just added as a second intervention is not what is called forth;
- Informed consent about both treatments is crucial; clarification of what kind of information can be shared between medication providing psychiatrist and psychotherapist.
- The psychotherapist´s own attitude towards medication should be clearly spelled out

16

Surprises

„Clearly, combined therapy is accepted better than pharmacotherapy by the patients to a significant extent.

Almost all of those refusing combined therapy refuse it because of its pharmacotherapeutic, not because of its psychotherapeutic aspect. The fact that many depressed patients refuse pharmacotherapy is a daily problem in clinical practice.“

de Jonghe F, Kool S, van Aalst G, Dekker J, Peen J (2001) Combining psychotherapy and antidepressants in the treatment of depression. J Affect Disord 64: 217-229

17

Treatment of Choice

„This study confirms our earlier result that the comorbidity of personality pathology in depressed patients has an effect on the result of the treatment. In addition, depressed patients are more likely to achieve remission if treated by a combination of antidepressants and a short form of psychoanalytic supportive psychotherapy than when treatment is limited to antidepressants.

The addition of psychotherapy to pharmacotherapy seems to be the treatment of choice in depressed patients with Axis II disorders“.

Kool S, Dekker J, Duijsens I, de Joghe F, Puite B (2003) Efficacy of combined therapy and pharmacotherapy for depressed patients with or without personality disorders. Harv Rev Psychiatry 11: 133-141

18

Final Issue: One or Two Hands?

Combined treatment in one hand - if expertise in both is secured - can make it easier for a patient, but not necessarily so depending on patient´s psychodynamics.

No RCT on this issue is available (as far as I know (Gunderson?)).

But an exploratory study demonstrated *fewer* outpatient utilization patterns and lower costs of integrated psychotherapy and pharmacotherapy for depression.

William Goldman, M.D.; Joyce McCulloch, M.S.; Brian Cuffel, Ph.D.; Deborah A. Zarin, M.D.; Ana Suarez, M.P.H.; Barbara J. Burns, Ph.D (1998) Outpatient Utilization Patterns of Integrated and Split Psychotherapy and Pharmacotherapy for Depression. *Psychiatric Services: 49(4):477-82.*

19