Combining Pharmacotherapy With Psychotherapeutic Management: Guidelines for Integration

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Most patients with Axis I disorders receive combined treatment rather than either medication alone or psychotherapy alone.[1,2] Unfortunately, the potential for integration of these therapies has generally not been fulfilled by a psychiatrist, in part because guidelines are lacking and in part because of financial disincentives to providing psychotherapy.[3]

A strong need exists for more specific recommendations for the practicing psychiatrist that support when and how to combine treatments over the course of these disorders. This column will focus on how the clinician can integrate medication and psychotherapy when the situation suggests that psychotherapy can improve outcomes for the patient and/or family above what medication alone provides.

Rationale for Combining Psychotherapy With Medication

The specific aims of combined treatment are to (1) quickly bring the patient into remission from the illness; (2) reduce the probability of delay in initiating treatment or eliminate relapse/recurrence; (3) treat both the symptoms of the patient and ameliorate the stress on the family; (4) enhance adherence to medication; (5) enhance psychosocial skills that were lost (or never learned) due to the existing psychopathology; (6) teach the patient and the family methods to cope with residual symptoms; and (7) accelerate the psychotherapeutic process.

Evidence for Combined Treatment Over Medication Alone

Controlled data[3] suggest that a combination of medication plus some form of psychosocial intervention is better than medication alone for 7 disorders: bipolar disorder, attention-deficit/hyperactivity disorder, major depressive disorder, schizophrenia, posttraumatic stress disorder, sleep disorders, and bulimia nervosa.

General Guidelines for Combining Treatments

The etiology of psychiatric illness is complex, involving multiple interactive domains that may require multiple interventions; therefore, combined therapy may be necessary. As a generalization, multimodal therapy (i.e., medication, a family intervention, and an individual therapy like cognitive-behavioral therapy [CBT]) may be necessary. Obviously, however, treatment must be individualized.

This section provides general guidelines that, by and large, cut across diagnostic categories. For specifics about combining medication, family intervention, individual intervention, and psychoeducation, the reader is referred to an article on the subject.[4]

Diagnosis. The most effective integration of combined treatments entails not only making a DSM-IV-TR diagnosis, but also understanding how the individual and the family functions.[5] Without a diagnostic map, the appropriate treatment may not be prescribed. So too, without a map of the individual and family system dynamics, the clinician will be oblivious to the quagmire of family and individual pathology and how it affects outcome.

Goals. After identifying and quantifying target symptoms (by severity, prominence, and impact on functioning), one must set goals for improvement over baseline levels of these target symptoms. This information will allow the clinician to determine which symptoms (or cluster of symptoms) may be responsive to which modalities. By setting goals, the clinician has a more quantifiable method of evaluating what interventions are effective.

Untoward effects. "Untoward effects" means not just side effects, but also adverse changes in individual and family dynamics as well as potentially adverse interactions of combined therapies. For example, medication-induced sedation or dysphoria may decrease the patient's ability to socialize with family and/or friends. Within the family dynamics, there may be issues involving perception of the patient needing less care or becoming more assertive, family members no longer perceiving the patient as ill or stigmatized, and, of course, the ensuing loss of secondary gain by being ill. On the other hand, increasing medication dosage may allow a patient (or family) to be able to discuss issues that were previously too emotionally charged for careful, insightful discussion.

Sequencing effects. The clinician who accepts the role of a "combination therapist" must be aware of when, and in what sequence, to use each of the modalities. Since good evidence is not available, the sequence will vary according to clinical considerations of the type of illness, its severity, and the clinician-patient concept of the nature of the illness. For instance, for psychosis, the clinician may want to medicate first, then add family and/or individual psychotherapy. In part, this is because of the lack of insight as well as the denial inherent in the illness.[5]

When not to combine treatments. If one modality is effective, do not add the second. For some clinical situations, start with family therapy (for example, when the family problem is paramount, and/or may interfere with individual psychotherapy or medication adherence); for others, start with medication (for example, in the acute psychosis associated with schizophrenia, bipolar disorder, and organic mental disorders). In still other situations, start both simultaneously and consider withdrawing one (or both) modalities over time (for example, as a marital family systems problem is resolved, the intervention can be tapered or discontinued). Much of the data on combined treatments appear to show that CBT reduces symptoms as well as the risk of relapse.[6] It may be that this conservative step should be taken first in less severe cases. The need for medication then may be reduced or eliminated.

When to combine treatments. One treatment may resolve one illness, but a second treatment may be needed for a comorbid disorder (for example, if a patient has a mood disorder comorbid with alcohol abuse requiring Alcoholics Anonymous intervention), for residual symptoms, or for long-term management. There are frequently residual symptoms after the patient no longer meets full DSM-IV criteria,[7] and for those situations, a psychosocial therapy like individual therapy might be needed to eliminate these symptoms, or family therapy might be needed to help the family cope. At the very least, putting aside the potential power of a family intervention by itself, the family systems approach is an efficacious way to increase medication compliance.

Advantages and Disadvantages of Combining Therapies

For biologically oriented patients, psychotherapy promotes a sense of increased collaboration and targets interpersonal and intrapsychic problems that are usually neglected. For those patients who are psychologically oriented, medication response can relieve the hopelessness associated with lack of improvement in psychotherapy as well as target the primary symptoms of the illness. Treatment response is faster overall when treatments are combined than when giving each modality alone. Medication (when it improves cognition) can improve the ability to engage

in psychotherapy. Similarly, each of the psychotherapies can promote medication compliance.

The side effects associated with medication may lead to early termination of all therapies (if, for example, a patient feels overmedicated), while the psychotherapy may decrease the perceived need for medication, e.g., "I can solve this on my own." Additionally, at least in the short run, there may be increased cost of combining therapies, although in the long run, costs usually are less if relapse and rehospitalization is prevented.

Conclusion

This column emphasizes 3 points: (1) biological and psychological factors are interactive; (2) psychotherapy added to medication may improve outcome above that produced by medication alone; and (3) psychotherapy plus medication may insulate better than medication alone against relapse in many disorders. These points can be used as working guidelines for the clinician to implement the quality care equation discussed in other articles.[4,8]

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