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Illness and Substance Abuse. New York: Guilford; 2003. Rudnick A, Eastwood D. Psychiatric rehabilitation education for physicians. Psychiatric Rehab J. 2013;36(2):126–127. Twamley EW, Jeste DV, Bellack AS. A review of cognitive training in schizophrenia. Schizophr Bull. 2003;29(2):359–382. Zisman-Ilani Y, Roe D, Flanagan EH, Rudnick A, Davidson L. Psychiatric diagnosis: What the recovery movement can offer the DSM-5 revision process. Psychosis. 2013;5(2):144–153. 28.13 Combined Psychotherapy and Pharmacotherapy The use of psychotropic drugs in combination with psychotherapy has become widespread. In fact, it has become the standard of care for many patients seen by psychiatrists. In this therapeutic approach, psychotherapy is augmented by the use of pharmacological agents. It should not be a system in which the therapist meets with the patient on an occasional or irregular basis to monitor the effects of medication or to make notations on a rating scale to assess progress or side effects; rather, it should be a system in which both therapies are integrated and synergistic. In many cases, it has been demonstrated that the results of combined therapy are superior to either type of therapy used alone. The term pharmacotherapy-oriented psychotherapy is used by some practitioners to refer to the combined approach. The methods of psychotherapy used can vary immensely, and all can be combined with pharmacotherapy when indicated. INDICATIONS FOR COMBINED THERAPY A major indication for using medication when conducting psychotherapy, particularly for those patients with major mental disorders such as schizophrenia or bipolar disorder, is that psychotropics reduce anxiety and hostility. This improves the patient's capacity to communicate and to participate in the psychotherapeutic process. Another indication for combined therapy is to relieve distress when the signs and the symptoms of the patient's disorder are so prominent that

they require more rapid amelioration than psychotherapy alone may be able to offer. In addition, each technique may facilitate the other; psychotherapy may enable the patient to accept a much needed pharmacological agent, and the psychoactive drug may enable the patient to overcome resistance to entering or continuing psychotherapy (Table 28.13-1). Table 28.13-1 Benefits of Combined Therapy The reduction of symptoms, especially anxiety, does not decrease the patient’s motivation for psychoanalysis or other insight-oriented psychotherapy. In practice, drug-induced symptom reduction improves communication and motivation. All therapies

have a cognitive base, and anxiety generally interferes with the patient’s ability to gain cognitive understanding of the illness. Drugs that decrease anxiety facilitate cognitive understanding. They can improve attention, concentration, memory, and learning in patients who suffer from anxiety disorders. NUMBER OF TREATING CLINICIANS Any number of clinicians can be involved in treatment of a psychiatric disorder. In oneperson therapy, the psychiatrist provides individual psychotherapy and medication treatment. Multiperson therapy is a form of treatment in which one therapist (who may be a psychiatrist, psychologist, or a social worker) conducts psychotherapy while the other therapist (always a psychiatrist) prescribes medications. Other therapists may oversee marriage or family therapy or group therapy. The terms cotherapy or triangular therapy are sometimes used to describe permutations of multiperson therapy. COMMUNICATION AMONG THERAPISTS Whenever more than one clinician is involved in treatment, there should be regular exchanges of information. Some patients split the transference between the two; one therapist may be seen as giving and nurturing, and the other may be seen as withholding and aloof. Similarly, countertransference issues, such as one therapist’s identifying with the patient’s idealized or devalued image of the other therapist, can interfere with therapy. Those issues must be worked out, and the cotherapists must be compatible and respectful of each other’s orientation, so that the therapy program can succeed. A therapist may have some concerns about the quality of the psychopharmacology or that the existing regimen needs to be reconsidered. For example, a patient may not be doing well on medication, experiencing significant side effects, or showing lack of sufficient improvement. Some patients may also be taking many different medications. When and if it is deemed in the patient’s interest to question the medication regimen or the prescriber’s skill, these misgivings should not be shared with the patient without first conferring with the prescribing physician. If the therapist or pharmacologist, after a good-faith effort to understand the methods and course of treatment, still has misgivings about treatment, he or she should inform his or her counterpart that a second opinion would be useful. This should then be suggested to the patient without necessarily raising undue alarm. Communication between treating clinicians should take place as frequently as needed. No standard exists for how frequent that should be. ORIENTATIONS OF TREATING CLINICIANS The orientation of the treating psychiatrist or other clinician can influence the therapeutic process during combination treatment. Clinicians invariably bring a theoretical bias to the treatment setting. Some, for example, are oriented, by preference

and training, to practice a specific form of psychotherapy, such as psychoanalysis, cognitive-behavioral therapy (CBT), or group therapy. To these clinicians, psychotherapy is seen as the primary treatment modality, with pharmacological agents being used as an adjunct. Conversely, to a psychopharmacologically oriented psychiatrist, psychotherapy is seen as augmenting the use of medication. Although disagreement may arise on which approach represents the most active ingredient in clinical response, the optimal use of both modalities should complement each other. In addition to having extensive training in one or more psychoanalytic or psychotherapeutic

techniques, the psychiatrist who practices pharmacotherapy-oriented psychotherapy must have a comprehensive knowledge of psychopharmacology. That knowledge must include a thorough understanding of the indications for the use of each drug, the contraindications, the pharmacokinetics and pharmacodynamics, the drug– drug interactions (with all pharmacological agents, not only the psychoactive agents), and the adverse effects of medications. The psychiatrist must be able both to identify adverse effects and to treat them. Nonpsychiatric physicians often use psychoactive agents inaccurately (too small or too large a dose for too short or too long a course), because they lack the requisite psychopharmacological knowledge, training, and experience. Psychotherapists who work with primary care physicians instead of psychiatrists should understand the limitations in depth of knowledge that these practitioners have and should seek a consultation with a psychiatrist if a patient is not responding to, or tolerating, medication. In some situations, it is preferable for psychotherapy and pharmacotherapy to be carried out by the same clinician; however, this is often not possible for a variety of reasons, including therapist availability, time limitations, and economic restraints, among others (Table 28.13-2). Table 28.13-2 Clinical Situations in Which It Is Advantageous for One Psychiatrist to Provide Medication and Psychotherapy Therapist Attitudes Psychiatrists trained primarily as psychotherapists may prescribe medication more reluctantly than those who are more oriented toward biological psychiatry. Conversely, those who view medication as the preferred intervention for most psychiatric disorders

may be reluctant to refer patients for psychotherapy. Therapists who are pessimistic about the value of psychotherapy or who misjudge the patient’s motivation may prescribe medications because of their own beliefs; others may withhold medication if they overvalue psychotherapy or undervalue pharmacological treatments. When a patient is in psychotherapy with someone other than the clinician prescribing medication, it is important to recognize treatment bias and to avoid contentious turf battles that put the patient in the middle of such conflict. Linkage Phenomenon At some point, patients may view the improvement being made in therapy as the result of a conscious or unconscious linkage between the psychopharmacological agent and the therapist. In fact, after being weaned from medication, patients often carry a pill with them for reassurance. In that sense, the pill acts as a transitional object between the patient and the therapist. Some patients with anxiety disorders, for example, may carry a single benzodiazepine tablet, which they take when they think they are about to have an anxiety attack. Then, the patient may report that the attack was aborted—before the medication could even have been absorbed into the bloodstream. In other cases, the pill is never taken, because the patient knows that the pill is available and gains reassurance from that fact. The linkage phenomenon is usually not seen unless the patient is in a positive transference to the therapist. Indeed, the therapist may use this phenomenon to his or her advantage by suggesting that the patient carry medication to use as needed. Eventually, the behavior has to be analyzed, and it is often found that the patient has attributed magical properties to the therapist that are then transferred to the medication. Some clinicians believe the effect to be the result of conditioning. After repeated trials, the sight of the medicine can decrease anxiety. The positive transference may also cause transference cure or flight into health, in which the patient feels better in an unconscious attempt to meet the presumed expectations of the prescribing physician. Therapists should consider this phenomenon if the patient reports rapid improvement well before a particular medication may reach its therapeutic level. Rachel, a 25-year-old white woman, presented with depressive symptoms and abdominal pain. After an extensive psychiatric and medical evaluation, she was diagnosed with major depression of moderate severity and

irritable bowel disorder. She began a course of CBT targeting her negative attributional style and low selfesteem, and she was taught relaxation and distraction techniques for her pain. After a 12-week trial, she experienced only partial remission of her symptoms and was offered an antidepressant, citalopram (Celexa) at 20 mg per day. Her depressive symptoms remitted within 1 month, and she was able to function better at work but socially remained hesitant to engage with her peers. Her abdominal pain persisted, and she began to exhibit a pattern of disordered eating, severely restricting her intake to 500 calories per day due to the "pain." She experienced a 15-pound weight loss

over the next several months. An intensive behavioral plan to target eating was begun, as well as continued probing of her negative cognitions relating to eating, pain, and newly emerging concerns that she would regain the weight too quickly and would become "fat." She did not meet weight loss criteria for anorexia nervosa, although her cognitive distortions about her body image were extreme. These new concerns resulted in a relapse of her depressive symptoms, including suicidal ideation, and her citalopram was increased to 40 mg per day. She reported severe akathisia on this dose and refused to take any more medication, including an antidepressant of another class. Rachel did agree to intensify her therapy to twice weekly, and this allowed her to explore some of her conflicts, feelings, and thoughts that fostered her treatment-refractory illness. A combination of psychotherapy and hypnosis was used for this work. Over the next 6 months, Rachel revealed that she had been sexually abused as a child and this made her feel that she did not "deserve" to live or to eat and that the pain served to "punish" her for being bad. She also admitted that she resisted the medication "psychologically" because she felt that she did not deserve to get well. Her newly found insight, as well as the coping skills she developed in therapy, resulted in a reduction of her depressive symptoms, marked improvement in her eating habits with normalization of her weight, and decreased abdominal pain. She maintained these gains over the next year, including normalization of her daily functioning, a promotion at work, and the ability to tolerate the intimacy of a boyfriend. (Courtesy of E. M. Szigethy, M.D., Ph.D., and E. S. Friedman, M.D.) COMPLIANCE AND PATIENT EDUCATION Compliance Compliance is the degree to which a patient carries out the recommendations of the treating physician. Compliance is fostered when the doctor–patient relationship is a positive one, and the patient's refusal to take medication may provide insight into a negative transferential situation. In some cases, the patient acts out hostilities by noncompliance, rather than by becoming aware of, and ventilating, such negative feelings toward the doctor. Medication noncompliance may provide the psychiatrist with the first clue that a negative transference is present in an otherwise compliant patient who had appeared to be agreeable and cooperative. Education Patients should know the target signs and symptoms that the drug is supposed to reduce, the length of time they will be taking the drug, the expected and unexpected adverse effects, and the treatment plan to be followed if the current drug is unsuccessful. Although some psychiatric disorders interfere with patients' abilities to comprehend that information, the psychiatrist should relay as much of the information as possible. The clear presentation of such material is often less frightening than are patients' fantasies

about drug treatment. The psychiatrist should tell patients when they may expect to begin to receive benefits from the drug. That information is most critical when the patient has a mood disorder and may not observe any therapeutic effects for 3 to 4 weeks. Some patients' ambivalent attitudes toward drugs often reflect the confusion about drug treatment that exists in the field of psychiatry. Patients often believe that taking a psychotherapeutic drug means they are not in

control of their lives or they may become addicted to the drug and have to take it forever. Psychiatrists should explain the difference between drugs of abuse that affect the normal brain and psychiatric drugs that are used to treat emotional disorders. They should also point out to patients that antipsychotics, antidepressants, and antimanic drugs are not addictive in the way in which, for example, heroin is addictive. The psychiatrist's clear and honest explanation of how long the patient should take the drug helps the patient adjust to the idea of chronic maintenance medication if that is the treatment plan. In some cases, the psychiatrist may appropriately give the patient increasing responsibility for adjusting the medications as the treatment progresses. Doing so often helps the patient feel less controlled by the drug and supports a collaborative role with the therapist. ATTRIBUTION THEORY Attribution theory is concerned with how persons perceive the causes of behavior. According to attribution theory, persons are likely to attribute changes in their own behavior to external events, but are likely to attribute another's behavior to internal dispositions, such as that person's personality traits. Research on drug effects by attribution theorists has shown that, when patients take medication and their behaviors change, they attribute it to the drug and not to any changes that occur within themselves. Accordingly, it may be unwise to describe a drug as extremely strong or effective, because if it does have the desired effect, the patient may believe that is the only reason he or she got better; if the drug does not work, the patient may assume his or her condition is incurable. Therapists do best by presenting the use of drugs and psychotherapy as complementary or adjunctive, as neither standing alone and both being needed for improvements or cure to occur. MENTAL DISORDERS Depressive Disorders Some patients and clinicians fear that medication covers over the depression and that psychotherapy is impeded. Instead, medication should be viewed as a facilitator in overcoming the anergia that can inhibit the communication process between doctor and patient. The psychiatrist should explain to the patient that depression interferes with interpersonal activity in a variety of ways. For instance, depression produces withdrawal and irritability, which alienate significant others who may otherwise gratify the strong dependency needs that make up much of depressive psychodynamics.

If medication is stopped, the psychiatrist should be alert for signs and symptoms of a recurrent major depressive episode. Medication may have to be reinstituted. Before doing so, however, carefully review any stress, especially rejections, that could have precipitated recurrent major depressive disorder. A new episode of depression may occur because the patient is in a stage of negative transference, and the psychiatrist must try to elicit negative feelings. In many cases, the ventilation of angry feelings toward the therapist without an angry response can serve as a corrective emotional experience, and a major depressive episode necessitating medication can thereby be forestalled. Depressed patients are generally maintained on their medication for 6 months or longer after clinical improvement. The cessation of pharmacotherapy before that time is likely to result in a relapse. Combined treatment has been shown to be superior to either therapy used alone in the treatment of major depression. It is associated with improved social and occupational functioning and improved quality of life compared with either therapy alone. Bipolar I Disorder Patients taking lithium (Eskalith) or other treatments for bipolar I disorder are usually medicated for an indefinite period of time to prevent episodes of mania or depression. Most psychotherapists insist that patients with bipolar I disorder be medicated before starting any insight-oriented therapy. Without such premedication, most patients with bipolar I disorder are unable to make the necessary therapeutic alliance. When those patients are depressed, their abulia seriously disrupts their flow of thoughts, and the sessions are nonproductive. When they are manic, their flow of associations can be rapid, and their speech can be so pressured that the

therapist could be flooded with material and may be unable to make appropriate interpretations or to assimilate the material into the patient's disrupted cognitive framework. The practice guideline of the American Psychiatric Association (APA) for bipolar disorder recommends combined therapy as the best approach. It increases compliance, decreases relapse, and reduces the need for hospitalization. Substance Abuse Patients who abuse alcohol or drugs present the most difficult challenge in combined therapy. They are often impulsive, and, although they may promise not to abuse a substance, they may do so repeatedly. In addition, they frequently withhold information from the psychiatrist about episodes of abuse. For that reason, some psychiatrists do not prescribe any medication to such patients, especially not those substances with a high abuse potential, such as benzodiazepines, barbiturates, and amphetamines. Drugs with no abuse potential, such as amitriptyline (Elavil) and fluoxetine (Prozac), have an important role in treating the anxiety or depression that almost always accompanies substance-related disorders. The psychiatrist conducting psychotherapy with such patients should have no reservations about sending the patient to a laboratory for

random urine toxicological tests. Anxiety Disorders Anxiety disorders encompass obsessive-compulsive disorder (OCD), posttraumatic stress disorder (PTSD), generalized anxiety disorder, phobic disorders, and panic disorder with or without agoraphobia. Many drugs are effective in managing distressing signs and symptoms. As the symptoms are controlled by medication, patients are reassured and develop confidence that they will not be incapacitated by the disorder. That effect is particularly strong in panic disorder, which is often associated with anticipatory anxiety about the attack. Depression can also complicate the symptom picture in patients with anxiety disorders and has to be addressed pharmacologically and psychotherapeutically. Studies have shown that patients with anxiety disorders who receive ongoing psychotherapy are less likely to experience relapse compared with patients who receive medication alone. Schizophrenia and Other Psychotic Disorders Included in the group of schizophrenia and other disorders are schizophrenia, delusional disorder, schizoaffective disorder, schizophreniform disorder, and brief psychotic disorder. Drug treatment for those disorders is always indicated, and hospitalization is often necessary for diagnostic purposes, to stabilize medication, to prevent danger to self or others, and to establish a psychosocial treatment program that may include individual psychotherapy. In attempting individual psychotherapy, the therapist must establish a treatment relationship and a therapeutic alliance with the patient. The patient with schizophrenia defends against closeness and trust and often becomes suspicious, anxious, hostile, or regressed in therapy. Before the advent of psychotropics, many psychiatrists were fearful for their own safety when working with such patients. Indeed, many assaults occurred. Individual psychotherapy for schizophrenia is labor intensive, expensive, and not often attempted. The recognition that combined psychotherapy and pharmacotherapy have a greater chance of success than either type of therapy alone may reverse that situation. The psychiatrist who conducts such combined therapy must be especially empathic and must be able to tolerate the bizarre manifestations of the illness. The patient with schizophrenia is exquisitely sensitive to rejection, and individual psychotherapy should never be started unless the therapist is willing to make a total commitment to the process. OTHER ISSUES Evidence suggests that therapy can induce physical changes in the nervous system. Eric Kandel has provided elegant proof, winning the Nobel Prize for demonstrating that environmental stimuli produce lasting changes in the synaptic architecture of living organisms. Imaging studies have begun to show that patients who show clinical

improvement from psychotherapy show changes in brain metabolism that are similar to that seen in patients successfully treated with medications. Still, some patients do well on only one form of treatment. Even with identical diagnoses, not all patients respond to the same treatment regimens. Success may be as dependent on the knowledge and quality of the clinician as on the potential benefit of a particular drug. A real dilemma when combining treatment is the additional direct costs of two treatments. Although successful treatment results in reduced costs to society, the cost of treatment is usually narrowly defined by the patient as out-of-pocket expenses and by insurance and managed care companies as payments to the physician or hospital. Restrictions placed on the frequency and cost of visits to mental health professionals by managed care organizations, however, encourage the use of medication rather than psychotherapy.

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Revision #1
Created 2026-01-04 19:51:34 UTC by Omar Ayman
Updated 2026-01-04 19:51:34 UTC by Omar Ayman