

Psychotherapy During Pharmacotherapy

The following chapter is used in this case discussion:

Integrating Psychotherapy and Pharmacotherapy – Dissolving the Mind-Brain Barrier by Bernard D. Beitman and Barton J. Blinder. Section 3: Psychotherapy During Pharmacotherapy.

Questions for Psychotherapy During Pharmacotherapy

Inpatient Case

1. A 26-year-old married woman with a history of bipolar affective disorder is admitted to the inpatient unit for depression with suicidal ideation. While you are introducing yourself, her husband, who is present in the room, asks you about placing the patient on oxcarbazepine (Trileptal) because he's heard it is less dangerous during pregnancy. You notice that the patient looks down while he is talking. You agree that the patient's medications probably need adjustment and think consideration of oxcarbazepine sound reasonable. What psychological aspects of the decision should be considered? Of note, the patient is not currently pregnant.

Emergency Department Cases

1. A 43-year-old married woman with no prior psychiatric history arrives in the emergency department complaining of acute-onset chest pain that awakened her from sleep. Her medical work up is negative and her symptoms improve with lorazepam (Ativan). You are asked to evaluate for panic disorder. While taking the history, you find that the patient recently returned to work now that her children are school age. However, the patient had to discontinue working shortly after commencing work due to anxiety symptoms. The patient refuses your referral to the psychiatric outpatient clinic for follow-up, stating that her symptoms are purely physical and that the doctors much have missed something. What psychological considerations might you have?

2. A 27-year-old married man, a graduate student in business school, is admitted to the hospital for a manic episode. He was walking naked in the streets talking loudly about "Jesus Christ." The patient refuses medications, stating that nothing is wrong with him. He tells you repeatedly that he is the smartest MBA student in his school. The following day, he approaches you to ask about a research study that one of the other patients on the unit had mentioned. The study is intended for

patients with bipolar disorder and you believe that patient might benefit from participating. What might you say to him?

3. An 18-year old woman is admitted to the inpatient ward with anorexia nervosa and depression. The patient is not gaining much weight and appears increasingly depressed. You and your team feel a trial of an antidepressant is warranted, but the patient refuses, saying she doesn't want medication and "doesn't care anyway" about feeling happier. Through your work with this patient you notice that one of the few things she seems to have enjoyed prior to admission was her job working as an assistant in a daycare center. She visibly brightens when talking about her love of babies. How might this history help you in explaining the risk/benefits of medications to this patient?

Outpatient Cases

1. A 37-year-old man with panic disorder and agoraphobia received effective treatment of his symptoms with imipramine (Tofranil). His wife often complained that part of their marital difficulty was due to his overlooking obvious problems in their marriage. Three months after his treatment, on a business trip to Hawaii, he felt so good that he decided to stop the medication. Six days later on his return home he had a major panic attack on the plane. He attributed the attack to his dislike of having to return home. There probably was another reason—one that could illustrate an interesting pattern of his. What might it be.
2. A 21-year-old woman with panic disorder and agoraphobia preferred to use phenelzine over imipramine because she did not want to have a dry mouth, be sedated, or possibly have orthostatic hypotension. She also refused to consider SSRIs (selective serotonin reuptake inhibitors) due to fear of sexual side effects. She was willing to follow the monoamine oxidase inhibitor dietary restrictions and work with her psychiatrist in psychotherapy. She responded very positively with a reduction in panic and phobic avoidance. Unfortunately, however, she became phobic not only of foods containing cheese but also of many other foods. She stopped the phenelzine but still would not eat a wide variety of foods because of her new set of phobias. She refused to follow her psychiatrist's suggestion to

utilize birth control and became pregnant. She quit psychotherapy. Speculate about what led to this patient-initiated termination.

3. A 43-year-old mother of three children, married since age 17, was seen by neurologist for a stroke caused by an intracranial bleed. She made a remarkable recovery but was referred to a psychiatrist for treatment of her agoraphobia and severe depression. She benefitted greatly from a combination of antidepressants, benzodiazepines, and psychotherapy. She and the psychiatrist not only examined the patient's "what if..." fears but also her lack of assertiveness with her husband, her tendency to give to others without asking for anything in return, and the consequent lack of concern shown her by her now-grown children. After 3 years she remained on medications because she had a history of recurrent depression. She was seen in follow-up visits about every 3 months. During one of these meetings she reported yet another problem that appeared beyond her control. Somewhat irritated, her psychiatrist said, "It seems like something negative repeatedly happens and because of that we will need to keep meeting." To her, this remark sounded very much like her husband's complaints that most problems were her fault. She became angry but did not report her reaction during the session. Instead she talked about how hard it would be if she had to see another therapist. She wondered if the psychiatrist liked her and felt that he did not. She was upset that he might leave the area sometime in the future. The next day she called to say she was stopping her medications. Why was she thinking about stopping her medications?

4. A 24-year old college senior was depressed and anxious. She loved her fiancé but was not sure she could enjoy their relationship. She was having difficulty concentrating at school, her grades were falling, and she was "faking" being happy. Just like her mother, she could convince people she was fine when actually she was miserable inside. Her mother had a history of major depression and had responded very positively to paroxetine 10 mg. Her maternal grandfather had committed suicide and a cousin had severe OCD (obsessive-compulsive disorder). She thought a maternal aunt had been hospitalized for depression. In retrospect, she felt she had been depressed more often than not since she was about 13. The patient started on paroxetine and had a dramatic positive response. She felt normal. She wanted to know about future treatment. Should she stay on the medication and begin psychotherapy? How long should she be on the medication? What would you tell her?

5. A 53-year-old mother of three children wanted help with depression and intense anxiety. At the time of the initial evaluation, she was in the midst of struggling to gain custody of her two grandchildren, who were being taken away from her daughter because of the daughter's inability to care for them. She had tried to make her daughter's life with them better by having all three of them move in with her, but could not. She was treated with sertraline 50 mg and clonazepam 0.5 mg bid. During her medication visits, she grieved the loss of the grandchildren, who were sent to live with other relatives out of town. She rebuked herself for failing to keep them with her. However, she was able to return to work and began socializing again. No longer was she staying home, going from "bed to couch," eating poorly, and feeling extremely unmotivated. She discontinued follow-up after a year and seven medication appointments. She returned 3 years later due to a recurrence of her depressive symptoms. She had been off all medications for 2 years. Her younger son's moving back in with her triggered the depressive reaction. He would not follow probation restrictions and was sent to a halfway house and then to jail again. She was very frustrated with his inability to care for himself. She could not make his life better. Further review of her history revealed that 9 years earlier her older son had died of AIDS. She had done all she could to keep him alive. As he was dying, she experienced her first major depressive episode. She could not save him. She began again on sertraline and clonazepam and gradually recovered sufficient function to return to work. What pattern seemed to trigger her depressive episodes?

6. A 40-year-old accountant for a Midwest company comes in for treatment for depression. He has been married for 20 years and has three children. His 16-year-old is being treated for ADHD (attention deficit disorder); his 14-year-old has spina bifida and behavioral problems. His 12-year-old is doing very well in school and appears not to be a problem for his family. The patient is being treated by the same psychiatrist for 2 years. His sessions last 20 minutes, with seven sessions per year. Visits focus on pharmacotherapy for the patient's recurrent depression. The patient is generally maintained on paroxetine 30 mg, with 60 mg required during particularly difficult periods. The patient came late to a session for about the fourth time. The psychiatrist asked him what was going on. He stated that he was caught up with the needs of some of his clients with whom he was consulting in another town, and rather than cut off the interview, he decided to stay as long as they needed him. He had many complaints about the difficulties with his wife but had continued to try to accommodate her wishes. What pattern is being illustrated during these medication checks?

7. A 29-year-old man came to pharmacotherapy evaluation for social anxiety. He feared not living up to expectations of others. He had previously taken paroxetine for this problem but because of significant sexual side effects, he discontinued it. However, the evaluating psychiatrist did not elicit this history. The psychiatrist had samples of paroxetine readily available and enthusiastically recommended it for the patient. The patient took the samples but did not take the pills. Why did he accept the pills when he intended not to take them?

8. A 34-year-old cocaine addict released from prison presented with major depression. She responded very well to sertraline 50 mg. She stated: "I felt much better. No depression, more energy, more optimistic. But I stopped it because I was no longer interested in sex and could not have an orgasm." Speculate about this decision.

9. A 48-year-old Vietnam War veteran had become a mercenary in Africa after the war. Subsequently, he hired himself out to governments in other parts of the world to help the armies to keep the civilian populations from rebelling. He stated that he had tried many medications for his depressive symptoms and none had worked. He doubted that anything could help him. His psychopharmacologist empathetically concurred with him that nothing was likely to help. Speculate about the reasons for this belief.

10. A 35-year-old alcoholic with polysubstance abuse had OCD symptoms but refused to take an SSRI for this problem and did not want to go through the rigors of behavioral therapy. He was afraid of the pills, and the behavior therapy (exposure and response prevention) seemed too difficult. Give several possible reasons for his reluctance to take medications.

11. A 35-year-old nurse is terrified of taking any medications for his severe panic disorder and agoraphobia. He tried a low dose of imipramine and felt dizzy. Yet he was having several panic attacks per day, at least one of which is typically very severe. He could not work and could not travel. His psychopharmacologist began with a very low dose of gabapentin and asked him to increase the dose very slowly. When the patient asked about side effects, the physician told him that “Gabapentin is associated with growing hairs on the palms of the hands.” The patient laughed. What psychotherapeutic principles were being used in the psychopharmacologist’s treatment?

12. A 45-year-old depressed man had spent the past 4 years seeing a variety of psychiatrist and primary-care physicians, each of whom had given him antidepressants, each of which he had stopped. When he started seeing a new psychiatrist, he again asked for antidepressants. What is the pattern and what therapeutic approaches might be considered?

13. A 48-year-old man had been depressed for more than 6 months. He had sought treatment from his primary care physician, who had prescribed trazodone (Desyrel) for sleep and venlafaxine (Effexor) for depression. He had difficulty gaining erections and had tried paroxetine with no success. He refused to try other SSRIs because of the sexual side effects. His sleep did not improve, nor did his depressive symptoms. He sought psychiatric help and was placed on mirtazapine (Remeron) 15 mg. He slept better though he was groggy during the day. During the next session, his psychiatrist—without reviewing the chart—discussed other possible medications. He suggested both venlafaxine and trazodone. The patient looked disappointed. They then decided simply to raise the mirtazapine because at higher doses it can be less sedating. The psychiatrist felt guilty about not having remembered the patient’s previous medications. What would you do in this situation?

14. A 28-year-old psychiatric resident was anxious in his dealings with his supervisors and colleagues. He seemed uncertain of his abilities to help patients. Very few of his patients were successfully treated with pharmacotherapy. Speculate about the reasons.

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