COMBINED THERAPIES IN GENERALISED ANXIETY DISORDER COMORBID WITH OBSESSIVE – COMPULSIVE PERSONALITY

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Abstract :
The common element within the comorbidity between GAD and OCPD is anxiety, manifested cognitively through a variety of worries. Combined therapy involving pharmacotherapy and cognitive – behavioural psychotherapy is a new and efficient approach for treating this comorbidity. OCPD is a factor supporting and aggravating GAD, so that it is recommended not only in order to reduce anxiety symptoms but also to exchange some maladaptive cognitive schemas with adaptive ones. The main goal of combined therapies is chronicity control within the two disorders. The beneficial effects felt by the patient include decrease of cognitive and emotional discomfort, with direct functional implications.
Key words: *pharmacotherapy, cognitive-behavioural therapy, maladaptive cognitive schemas*

Rezumat:
Elementul comun în cadrul comorbidităţii dintre TAG şi TPOC îl constituie anxietatea, manifestată la nivel cognitiv prin numeroase îngrijorări. Terapia combinată dintre farmacoterapie şi psihoterapia cognitiv-comportamentală constituie o abordare nouă şi eficientă în ceea ce priveşte tratarea acestei comorbidităţi. TPOC reprezintă un factor de menţinere şi de agravare a TAG, astfel că, este recomandată nu doar reducerea simptomelor anxioase, ci şi schimbarea unor scheme cognitive dezadaptative cu unele adaptative. Obiectivul principal al terapiilor combinate îl reprezentă controlul cronicizării în cadrul celor două tulburări. Efectele benefice resimţite de pacient constau în diminuarea disconfortului cognitiv şi afectiv, având implicaţii directe în plan funcţional.
Cuvinte cheie: *farmacoterapie, terapie cognitiv-comportametantală, scheme cognitive dezadaptative*

IMPLICATIONS, PREVALENCE AND COMORBIDITY

Anxiety involves subjective feelings (for instance worrying), physiological responses (such as tachycardia, hypercortisolemia) as well as behavioural responses (such as avoidance) (1). DSM-IV defines generalised anxiety disorder (GAD) as a state of excessive anxiety and preoccupation (apprehensive expectation), symptoms which are present more often than not, and which last for a period exceeding 6 months. Anxiety and preoccupation are accompanied by at least three symptoms such as disquiet, rapid fatiguability, difficulty in concentrating, muscle tension and sleep disturbance. The anxiety and preoccupation are not focused on the elements of another Axis I disorder and do not occur exclusively in post-traumatic stress (2). The prevalence of GAD is 2.5 – 6.4% throughout a lifetime, occurring with a higher probability in females (3). These patients are more likely to develop a sole or mixed personality disorder (4).

Second to substance abuse, anxiety disorders are one of the most frequent psychiatric problems in the United States of America, the prevalence being 31% in the general population (5).

In diagnosing GAD, due to medical investigations which do not include a psychiatric consult as well, the likelihood of a misdiagnosis is high. Thus, half of the costs of treating GAD are directed towards useless clinical investigations. A financial analysis conducted in France, quantifying the costs involved in treating GAD, revealed the fact that additional medical assistance, such as internal medicine, emergency assistance and laboratory analyses, additionally increases the costs of treating this disorder. For a period of 3 months, one patient's treatment reached $733 for simple GAD, and $1208 in the case of a comorbidity. The indirect costs are associated with the inability to work, and have been estimated at $233 for simple GAD and $416 in the case of a comorbidity. In other words, a psychiatric consult performed in the beginning would contribute to a correct diagnosis of GAD and implicitly to decreasing associated costs (6).

Obsessive–compulsive personality disorder (OCPD) is characterised by exaggerated self control, both personally and in terms of interpersonal relationships. The cognitive strategies of people affected by OCPD are based on extreme self discipline, leading to mannerism, meticulousness and perfectionism. These people have preoccupations which involve an excessive inclination towards order and details in their daily activities (7). Their critical behaviour towards their peers force them to make efforts in order to maintain a discipline of self – constraint. Such people hardly ever relax, and almost never give up their defensive behaviours. They are usually perceived as

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Received February 13, 2012, Revised March 26, 2012, Accepted April 09, 2012

serious, sad and tense people, having high moral standards (8).

From an epidemiological point of view, OCPD is the most common personality disorder (PD), with a prevalence rate of 4%. (9) With regard to the comorbidity between PD and Axis I of the DSM - IV, studies reveal that Cluster C presents a co-occurrence with anxiety disorders and hypochondria (10). Also, Cluster C personality disorders predominantly occur in young patients, being strongly correlated with Axis – I disorders (11). McGlashan et al, in a longitudinal study, established that 75.8% of the patients diagnosed with OCPD presented a comorbidity with the major depressive episode, and 29.4% presented a comorbidity with generalised anxiety disorder (12). These people live in an almost permanent state of internal tension, so that it eventually becomes an integral part of their being. Under these conditions, it is difficult to distinguish personality pattern from clinical syndrome (13).

COMBINED THERAPIES – PHARMACOTHERAPY AND COGNITIVE – BEHAVIOURAL PSYCHOTHERAPY

Drawing up a therapy plan involves a dimensional approach, which would not consider the PD pattern as being completely different from Axis I disorders. Treatment through forms of psychotherapy the efficiency of which has been scientifically proven for Axis – I disorders is also beneficial for many patients suffering from personality disorders (14). Pharmacotherapy and psychotherapy can be used at the same time.

Pharmacotherapy can be employed successfully in treating GAD, by using antidepressant medication, benzodiasepines or azapirones. The SSRI and SNRI drugs recommended for GAD are Escitalopram, Paroxetine, Venlafaxine and Duloxetine (15, 16). From the point of view of combined therapy versus monotherapy, associating Diazepame with cognitive – behavioural therapy (CBT) for a period of 10 weeks in treating GAD had superior therapeutic results compared to a form of treatment involving monotherapy (16). The results of combined therapy were significantly better, even in the comorbidity between the depressive episode and Cluster C PDs, in contrast with a sole form of treatment (17).

Psychotropic medication can also be useful in severe personality disorders, due to the fact that it alleviates cognitive and affective disorders, thus facilitating psychotherapeutic intervention (18). Using psychotropic medication in treating the comorbidity between GAD and OCPD is recommended ever since the beginning of the combined treatment (19).

The response to CBT on the part of the patients manifesting a comorbidity between an Axis I disorder and a PD, compared to patients only manifesting an Axis I disorder, does not differ or differs insignificantly (20). Reviewing 9 clinical studies focused on the benefits of cognitive therapy in treating GAD revealed the fact that most proof supports the efficiency of cognitive therapy in treating this disorder. A subsequent review of similar studies lead to the same conclusion (21). The limitations of these studies are related to the period of time for which the patient is monitored, and which in few cases exceeds twelve months (22).

The psychotherapeutic approach of the comorbidity between GAD and OCPD through CBT has two distinct stages. The first stage aims to alleviate the acute symptoms generated by GAD. The second stage will focus on altering the maladaptive cognitive schemas related to the self and to others, which occur in OCPD. Special emphasis will be placed on developing the therapeutic relationship, on psychoeducation, on assessing the client's strengths and on consolidating positive change, and last but not least, on the strategies meant to prevent relapse. The initial sessions for treating GAD will take place in accordance with standard CBT criteria (23).

Anxiety disorders are explained in terms of the cognitive pattern, based on explaining the erroneous interpretations of the individual, who perceives imminent threats in normal/day-to-day life situations. These distortions are caused by latent schemas/patterns of reality, which filter information in such a manner that they continually reinforce patterns of thinking centred on anxiogenic stimuli. The content of these thinking schemas is expressed by way of automatic thoughts (24). The CBT approach initially requires the altering of automatic negative thoughts, followed by the alteration of intermediate beliefs and ultimately of the core beliefs (25).

The maladaptive cognitive schemas present in personality disorders represent stable, generalised patterns which begin developing in childhood; their identification and understanding are useful in treating a wide range of psychopathological conditions. With the exception of PDs, schemas are more dimensional than categorial, and more cognitive–affective than behavioural. These schemas arise conceptually both from a traditional psychological approach to personality and from a cognitive phenomenological perspective, being less subordinate to operationalised psychiatric nosologies or to those of descriptive psychopathology (26).

In order to facilitate the difficult process of identifying and altering the patient's maladaptive schemas, the therapist requires many qualities. The therapeutic relationship necessitates empathy, warmth, and even a little humour is recommendable. The therapist's creativity plays a vital role, and a higher level of creativity stimulates the therapeutic dialogue better (27). Discussing possible modifications of maladaptive strategies with the patient is done by using the Socratic dialogue. The consequences of these changes must also be discussed. The patient is reluctant to change, due to painful feelings he or she has felt ever since childhood and which lead to the formation of the maladaptive cognitive schemas. The patient can interpret the new adaptive strategies as sources of distress and disadvantageous to him or her. Recontextualising some relationships with parental figures from the past, rational–emotive role-play combined with behavioural techniques contribute to change and assist it (28). The purpose of CBT, along with psychotropic medication, is that of removing or diminishing the psychological and emotional discomfort experienced by the patient, teaching and helping him or her to control the symptoms generated by the chronic nature of the two disorders as much as possible and for as long as possible. Behavioural techniques such as exposure and response prevention, in-vivo or in-vitro exposure to anxiogenic stimuli, thought stopping or thought normalisation are recommended (19). These techniques will be accompanied and combined

within each session with therapeutic strategies of a cognitive nature. At the same time, performing behavioural experiments and using relaxation techniques have the purpose of reducing the anxiety level and implicitly the level of muscular tension (29). There are studies which show that the progressive muscle relaxation (PMR) technique is efficient in treating anxiety (30).

Scheduling activities and rewards as a means of improving one's emotional state, writing in a "Worry Diary" and desensitization can also prove to be useful techniques (31). The verbal reattribution method refers to the therapist's posing a set of questions, for the patient to argue the reasons which make him/her believe that the worries might hurt him/her. The purpose of this exercise is to make the patient aware of the fact that he/she has no clear proof which would support the worries (32).

A strength of CBT resides in the fact that patients with OCPD prefer a therapy which is structured and focused on issues, rather than therapies focused on the transfer relationship or on the process (33).

One must take into consideration that patients with PDs are extremely sensitive in noticing the disagreements between the specialists treating them. The "psychotherapeutic triangle" refers to the relationship between the psychotherapist, when this is not a medical doctor, the attending physician and the patient. It is important that each specialist attempt to respect what the other is trying to accomplish. Thus, respect for the treatment should be separated from one's own opinions or feelings. The existence of a communication channel between the two specialists facilitates collaboration and coordination in the treatment of a common patient (34).

The treatment combined with antidepressants and CBT proved to be efficient in major or chronic depression, anxiety disorders and bulimia nervosa. Combining treatment in psychoses has constantly proven the advantages of including CBT along with anti-psychotic medication. The only exception is represented by the association between alprazolam and CBT, in which case short term negative interactions can occur, in the sense that the efficiency of the psychotherapeutic techniques of behavioural exposure may be diminished. Alongside psychotropic medication, CBT has biochemical effects, and combined therapies can act in conjunction in order to influence biochemical imbalances (35, 36).

In conclusion, the treatment formed by combining CBT and pharmacotherapy is a viable choice, as it is useful and efficient in the case of patients presenting a comorbidity of GAD and OCPD.

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