

WHEN MEDICATIONS FAIL.
USING PSYCHOTHERAPY IN THE PSYCHOPHARMACOLOGY SETTING

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Abstract

Throughout this special issue authors first discussed aggressive medication management strategies and suggested routine use of rating scales to promote remission in our patients. Then, authors took readers on a review based journey to suggest that technology, by way of genetics, neuroimaging and neuromodulation may be a profitable direction for modern day and future psychopharmacologists to pursue when initial medication management strategies fail. Next is an area that psychopharmacologists sometimes lose site of and insidiously lose their skill sets in – psychotherapy. Just as previous manuscripts hinted that treatment resistance can be caused by genetic and neurodegenerative brain processes, psychological and behavioral factors, stemming from either patient or provider, can strongly influence treatment resistance or treatment success. This paper will illustrate how psychopharmacologists must continue to be aware of these issues and work to retain and advance their psychotherapeutic knowledge base and skill sets in order to: make more accurate diagnoses; utilize psychotherapy referrals more advantageously; improve therapeutic alliance, placebo response and medication adherence; and ultimately promote remission in our patients while simultaneously improving our work satisfaction.

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Introduction

Understanding and being able to utilize psychotherapeutic principles is a powerful asset in treating not only a clinician's newest pharmacotherapy patient, but also his or her most challenging and treatment resistant one. Modern clinical trials of psychotherapy, with or without pharmacotherapy, have not only demonstrated benefit in the majority of Axis I diagnoses, but also in some of the most challenging Axis II diagnoses. Also, the wealth of psychodynamic and psychoanalytic theories, techniques and literature amassed over more than a century provides a perfect complement to modern diagnostic strategy and clinical trial design. This is especially true for the comorbid, treatment resistant patient for whom no regulatory, randomized controlled trial seems to fit. David Mintz writes, "A conventional symptom – or diagnosis-based treatment approach considers the ways that patients are similar. This kind of approach brings with it an established evidence base and is a foundation of rational psychopharmacologic practice, offering critical guidance about what to prescribe to enhance the likelihood of a positive outcome. In a complementary fashion, psychodynamic psychopharmacology considers what is unique to the individual patient" (Mintz and Belnap 2006).

Many, if not most, psychiatrists already draw from both their psychotherapy and pharmacotherapy backgrounds in their practice. They may integrate formal psychotherapy along with pharmacotherapy, collaborate with other psychotherapists in a split treatment model, or utilize psychotherapeutic principles and techniques within the confines of a traditional pharmacotherapy practice. This chapter targets the pharmacotherapist, but may also be useful for those working in integrated treatment models. It is broken up largely into three parts. The first part considers formal trials of psychotherapy as treatment entities similar to any other in medicine. Specifically, when it should be prescribed and what the data is for combining both. The second part compares advantages and disadvantages of the split treatment model to an integrated one, and provides tips for navigating some of the pitfalls. The third part is devoted to incorporating psychotherapeutic principles and techniques in the context of traditional pharmacotherapy sessions with special emphasis on psychodynamic factors and the physician-patient relationship. It is well known that a positive therapeutic alliance and desire for change can have a strongly positive effect on outcome regardless of treatment (Krupnick et al. 1996, Martin et.al 2000, Metz 2000, Beitman et al. 1994, Mintz 2009, Walsh et al. 2002, to name a few). Psychotherapy teaches us how

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to go about achieving these conditions by not only teaching us about psychotherapeutic formulations of wellness and disease, but also teaching us about empathic listening, understanding symbolic meanings of symptoms and medications, negotiating natural tensions that occur in therapeutic relationships, and working with issues of transference and countertransference (Tasman 2002).

Part 1. Prescribing psychotherapy and pharmacotherapy

Conceptualizing formal treatment trials of psychotherapy as treatment entities similar to medications is easiest when the psychiatrist prescribing the medication is not the therapist, a *split model*. Then, the psychiatrist can essentially write a prescription for psychotherapy much like writing a prescription for any medication. In both cases, an *other* is performing the prescribed treatment. Much of the recent literature looking at combining psychotherapy and pharmacotherapy uses this model. Dowd and Janicak recently wrote a book in this spirit in which they developed helpful algorithms for how and when to combine psychotherapy and pharmacotherapy for a variety of major psychiatric illnesses (2009).

Part 1a. Guidelines for psychotherapy as first line or primary treatment

The American Psychiatric Association (APA) practice guidelines specify that either psychotherapy alone or pharmacotherapy alone can be considered first line treatment for obsessive-compulsive disorder (OCD), major depressive disorder (mild-moderate), and panic disorder (2005b, 2007b, 2009a). Furthermore, that barring comorbidities requiring medication, patient preference should guide the decision of whether psychotherapy or medication is prescribed first. Dowd and Janicak further differentiate OCD and panic disorder into mild, moderate and severe (2009). They recommend psychotherapy first line for mild cases of either OCD or panic, pharmacotherapy first-line for moderate-severe OCD cases and severe panic cases, and either pharmacotherapy or psychotherapy for moderate panic cases. The APA recommends that for borderline personality disorder, eating disorders, and substance use disorders, psychotherapy should be considered the primary treatment with medications playing an adjunctive role (2005a, 2006, 2007a). Conversely, for major depressive disorder (moderate-severe), bipolar disorder and schizophrenia, the reverse is recommended. Pharmacotherapy should be considered the primary treatment with psychotherapy playing an adjunctive but important role (American Psychiatric Association 2005b, 2005c, 2009c). Also, the jury is out on Posttraumatic Stress Disorder (PTSD). The Institute of Medicine's Committee on Treatment of PTSD recently performed a systematic review of the literature for combat related PTSD and found that exposure therapy was efficacious, but that there was not enough evidence to determine the efficacy of medications or other forms of psychotherapy. As a

result, they concluded that exposure therapy should be strongly considered in the treatment of PTSD (Institute of Medicine 2007). The APA guidelines found evidence supporting both exposure therapy and pharmacotherapy (2009b).

Part 1b. Combining medications and psychotherapy

There are several combination strategies including adding medication to psychotherapy, adding psychotherapy to pharmacotherapy, combining both from the beginning, transitioning from one approach to another, and transitioning from combined treatment to a single approach (Dowd and Janicak 2009). Despite little data guiding us as to which combination strategy is ideal, all are generally used clinically. Practicality combined with individual patient and provider preference likely provides the greatest influence over which strategy is used.

Pros and cons of combining medications and psychotherapy

Some of the benefits and risks of combined treatment in any particular patient at any particular time include the following (Wright and Hollifield 2006, Szigethy and Friedman 2009, Kay 2009):

Hypothesized benefits of adding medication to psychotherapy:

1. Improve acute symptoms such as depression, anxiety, paranoia, hyperarousal, agitation, concentration and energy, which in turn help the patient participate in and learn from psychotherapy. Although psychotherapy may also improve these symptoms, medications may improve them faster, and the combination may be faster than either treatment alone.
2. Reduce therapy interfering distorted or irrational thinking.
3. Stabilize ego functions.
4. Increase placebo effect of therapy.
5. Improve the therapeutic relationship with the therapist.
6. Decrease the stigma associated with mental health treatment.
7. Provide valuable insights into the patient's personality and emotional responses as the patient deals with beliefs about medications and both the beneficial and adverse effects of the medications.
8. Help patient feel that they are being treated holistically.

Hypothesized risks of adding medication to psychotherapy:

1. May interfere with learning secondary to either the primary or adverse effects of medication, e.g., benzodiazepines.
2. May increase risk of relapse after medication discontinuation.
3. Could prematurely decrease target symptoms that may reduce motivation for psychotherapy.
4. May imply that patients cannot handle their

illness or that the therapist is giving up on them.

5. May cause negative transference reactions.
6. May decrease patient's desire to change or gain insight into problems.

Some hypothesized positive aspects of adding psychotherapy to pharmacotherapy:

1. Improve medication adherence.
2. Help patients better conceptualize and manage their illness.
3. May increase placebo effect of medication.
4. Help deal with stressors, develop more effective coping strategies, and gain self-understanding and acceptance.
5. Help patients through major life events such as the mourning process of grief and loss.
6. Improve interpersonal and occupational functioning.
7. Improve primary support relationships such as with spouse or family.
8. Help to prevent relapse if medication is discontinued.
9. Could have biological effects that work synergistically with medication to treat the illness.
10. Combined treatment may improve symptoms faster than either alone.
11. Decrease likelihood of exacerbations of symptoms, even in the most severe disorders.
12. Improve the therapeutic relationship with providers and increase patient satisfaction with mental health treatment overall.

Some hypothesized negative aspects of adding psychotherapy to pharmacotherapy:

1. May increase anxiety, hyperarousal, and agitation, which could be destabilizing.
2. May lead to therapist ignoring biological factors and placing too much responsibility on the patient.

Efficacy of combined treatments

Much of the research on combined treatment has been reviewed in recent textbooks (Hellerstein 2009, Vesga-López and Blanco 2009, Kay 2009, Friedman and Thase 2009, Szegedy and Friedman 2009, Rutherford et al. 2008, Riba and Balon 2008, Thase 2003). We will briefly review some of this literature as it pertains to depression, OCD, panic, and social phobia.

Depression. Many studies compared combined treatment to either psychotherapy alone or to medication alone in depressed patients. While early small studies demonstrated minimal benefit from combination therapy, Thase and colleagues pooled the data in a meta-analysis comparing combined treatment with psychotherapy alone in 595 patients with non-bipolar, non-psychotic major depressive disorder (1997). Psychotherapies studied included interpersonal psychotherapy (IPT) or cognitive behavioral therapy (CBT) delivered over 16 weeks. Recovery rates for less severely depressed patients were not significantly different between psychotherapy alone (37%) and combined treatment (48%). However, combined treatment fared significantly better with the more

severely depressed with 25% and 43% respectively. Pampalona and colleagues looked at the complementary scenario of comparing combined treatment with medication alone in a meta-analysis of 16 studies with 1842 patients with major depressive disorder (2004). Psychotherapies studied included problem solving, IPT, CBT, cognitive therapy, behavioral therapy, marital therapy, psychodynamic therapy and social skills training. Combined treatment resulted in an odds ratio (OR) of depression response of 1.86 (95% confidence interval (CI), 1.38-2.52), demonstrating a significant advantage to combined treatment. An important limitation of most studies comparing medication alone to combined treatment is that patients are not blinded to assignment because they know if they are receiving psychotherapy and hence placebo effect is not known.

Friedman and colleagues compared combined treatment to either psychotherapy or medications alone and found similar results to the above acknowledging a small improvement in efficacy with combined treatment (2004). They also noted that adding psychotherapy to medications might be especially helpful for chronic or more severely depressed patients and for helping prevent relapse among patients who discontinue medications. Hollon and colleagues also performed a broad review of the adult and geriatric depression literature with the goal of helping the psychiatrist decide when to choose medication alone, psychotherapy alone, or both together (2005). They concluded that in treating depression: 1) medication works rapidly and robustly, but has risk of relapse if discontinued; 2) IPT may work more slowly, but eventually works as well as medication in decreasing distress, and may be more helpful in improving interpersonal skills and social adjustment; 3) CBT is as effective as medications in reducing distress in less severely depressed patients, has enduring effects even after treatment discontinuation, and can help prevent relapse after discontinuation of medications; and 4) combined treatment results in modest improvement in response, and even more for patients with either severe or chronic depression, and retains any specific advantages associated with each of the individual treatments.

Cuijpers and colleagues recently performed two meta-analyses, which included some additional trials not included in prior meta-analyses; one comparing combined treatment with pharmacotherapy alone, and the other comparing combined treatment with psychotherapy alone (2009a, b). The study comparing combined treatment versus psychotherapy alone included 19 studies with 1838 subjects with a depressive disorder (Cuijpers et al. 2009a). Psychotherapies studied included IPT, CBT, supportive psychotherapy, psychodynamic psychotherapy, self control therapy, problem solving therapy, group CBT and group supportive therapy. The mean effect size of combined treatment as compared to psychotherapy alone was small to moderate, Cohen's *d* of 0.35 (95% CI: 0.24-0.45; $p < 0.001$). The study comparing combined treatment versus medication alone included 2036 patients with either major depressive disorder or dysthymia in 25 trials (Cuijpers et al. 2009b). Psychotherapies studied included CBT, cognitive behavioral-analysis system of psychotherapy, IPT,

psychodynamic, rational-emotive therapy, dialectical behavioral therapy, problem-solving therapy, cognitive-interpersonal group psychotherapy, treatment initiation program, and social skills training. The mean effect size of combined treatment compared with pharmacotherapy alone was small but highly significant, Cohen's *d* of 0.31 (95% CI, 0.20 - 0.43, $p < 0.001$). On subgroup analysis, they noted that psychotherapy provided no additional value for patients with dysthymia (Cohen's *d* of 0.00), but did for those with major depressive disorder (Cohen's *d* of 0.40). They also did not note a relationship between baseline severity of depression and effect size thereby concluding that addition of psychotherapy is helpful for either mild or more severe forms of major depressive disorder. Finally, they found that dropout rates of combined treatments were significantly lower than pharmacotherapy alone OR = 0.65 (95% CI, 0.50~0.83).

The Treatment for Adolescents with Depression Study (TADS) enrolled 439 adolescents with major depressive disorder and compared CBT alone, fluoxetine alone, combined treatment, and pill placebo (TADS Team 2009). Again, no therapy placebo group was utilized. They evaluated patients at 12, 18 and 36 weeks of treatment, and then after 12 months of naturalistic follow-up after discontinuation of treatment. Their conclusions following the last stage of evaluation were: "1) combined treatment meaningfully accelerates recovery from depression relative to CBT and fluoxetine, 2) longer-term treatment [irrespective of modality] results in improved outcomes relative to short-term treatment, 3) longer-term treatment may decrease the chances of relapse or recurrence when treatment is discontinued, and 4) adding CBT to fluoxetine minimizes persistent suicidal ideation and treatment-emergent suicidal events associated with medication monotherapy".

Depression: combined treatment conclusions. What conclusions can be drawn from the above information? 1) Combined treatment confers small to moderate benefit compared with either treatment alone in adults or adolescents with major depressive disorder. 2) The benefit of combined treatment may be larger with either severe or chronic depression, but the results are variable with some meta-analyses demonstrating a relationship between baseline severity and effect size and others not. Therefore patients with mild, moderate or severe major depression could be considered for combined treatment. 3) Combined treatment versus medication alone is less helpful for patients with dysthymic disorder. 4) CBT may be helpful in preventing relapse in depression patients who discontinue antidepressants. 5) CBT may be helpful in minimizing adolescent suicidal ideation and treatment-emergent suicidal events associated with antidepressant use in major depression.

Panic disorder. A recent Cochrane review compared combined antidepressant and psychotherapy with either treatment alone in 21 randomized controlled trials of 1709 patients with panic disorder (Furukawa et al. 2009). Psychotherapies studied included behavioral and CBT. They found that in the acute phase of treatment, combined treatment was superior to pharmacotherapy, relative risk (RR) 1.24 (95% CI, 1.02 - 1.52), or psychotherapy, RR 1.17 (95% CI, 1.05 -

1.31). After termination of treatment, the combined treatment was more effective than pharmacotherapy alone, RR 1.61 (95% CI, 1.23 - 2.11), and was as effective as psychotherapy, RR 0.96 (95% CI, 0.79 - 1.16). They concluded that "either combined therapy or psychotherapy alone may be chosen as first line treatment for panic disorder with or without agoraphobia, depending on patient preference." A recent Cochrane review looking at trials comparing the combination of psychotherapy and a benzodiazepine with either psychotherapy or benzodiazepine alone for people with panic disorder found that not enough evidence was available to evaluate (Watanabe et al. 2009).

Obsessive-compulsive disorder. There have been several recent randomized controlled trials that have looked at the combination of medications and psychotherapy for treatment of OCD. The Pediatric OCD treatment study compared CBT, sertraline, combined treatment, or pill placebo in 112 children and adolescents ages 7 to 17 with OCD (POTS Team 2004). With regards to change in CY-BOCS score, all three treatments were better than placebo. Furthermore, combined treatment was more effective than CBT alone and sertraline alone, and the latter two were not different from each other. In terms of rates of remission, combined treatment, 53% (95% CI, 36%-70%), did not differ from CBT alone, 39.3% (95% CI, 24%-58%), but was superior to sertraline alone, 21.4% (95% CI, 10%-40%), and pill-placebo, 3.6% (95% CI, 0%-19%).

Another pill-placebo controlled RCT compared exposure and response prevention (ERP), clomipramine, and their combination in treatment of OCD in 122 adult patients with no other psychiatric comorbidity (Foa et al. 2005). Using Y-BOCS score as the main outcome, all three treatment groups had lower scores than placebo. Furthermore both ERP and combined treatment were superior to clomipramine alone, and there was no difference between ERP alone and combined treatment. Response rates via CGI improvement scales were 70% for the combined group, 62% for ERP, 42% for clomipramine and 8% for placebo. However, there was no comparator/placebo arm for the psychotherapy group, which has been critiqued previously (Smith and Mathur 2006).

A recent trial looked at augmenting pharmacotherapy with CBT in 108 adult outpatients with OCD (Simpson et al. 2008). Patients were selected if they improved at least minimally from an adequate serotonin reuptake inhibitor trial, yet remained moderately ill, Y-BOCS score ≥ 16 . Furthermore, some co-morbid psychiatric diagnoses such as depression were allowed if they were thought to be secondary to the OCD. Additionally, CBT was divided up into an ERP subgroup versus a stress management training subgroup, which represents one of the few trials attempting to differentiate out specific treatment effects of the target psychotherapy for OCD as compared to a model of CBT shown effective in other non-OCD anxiety disorders. Using Y-BOCS scores, ERP resulted in greater symptom reduction than stress management training after 17 sessions (8 weeks). Furthermore, 75% of patients receiving ERP achieved responder status versus only 22% in the stress management training group. Also, ERP helped 33% of patients achieve

minimal symptoms as compared to stress management training, which only helped 4%. More sessions may be required for ERP to help a majority of patients achieve minimal symptoms.

Obsessive-compulsive disorder: conclusion. 1) Combined ERP and pharmacotherapy or ERP alone should be considered first line treatment for OCD. 2) ERP is helpful when added to SSRI partial responders.

Social phobia. One study using primary care physicians as the therapists, compared exposure therapy, sertraline, and combined treatment in 387 patients with social phobia and found that while both combined treatment and sertraline were more effective than placebo, combined treatment was not superior to sertraline alone (Blomhoff et al. 2001). Another study comparing group CBT, fluoxetine, and combined treatment in 295 patients with social phobia demonstrated that while all three treatments were more effective than placebo, there were no specific advantages conferred by combined treatment (Davidson et al. 2004). On the other hand, a recent study comparing group CBT, phenelzine, combined treatment and placebo in 128 patients showed much more positive effects of combined therapy (Blanco et al. 2010). They found that combined treatment was more efficacious than either group CBT or phenelzine alone with CGI based response rates at 24 weeks of 78.1% for combined treatment, 48.6% for phenelzine, 52.9% for group CBT and 33.3% for placebo. Remission rates at 24 weeks were 53.1% for combined treatment, 25.7% for phenelzine, 23.5% for group CBT and 14.8% for placebo. In conclusion, combined treatment may be helpful for social phobia, but more studies are clearly needed.

Part 2. Technicalities of combined treatment: The integrated and split treatment models

Once patient and provider agree that combined treatment would be helpful, the second question is who provides which treatment. In an integrated treatment model, a single practitioner provides both pharmacotherapy and psychotherapy. In a split, or collaborative treatment model, one practitioner provides the pharmacotherapy and another provides the psychotherapy.

Trends in delivery of mental health care

A recent study looked at percentages of psychiatry visits dedicated to psychotherapy from the 1996–2005 National Ambulatory Medical Care Survey of 756 office based psychiatry practices in the United States (Mojtabai and Olfson 2008). They used a strict definition of psychotherapy as “all treatments involving the intentional use of verbal techniques to explore or alter the patient’s emotional life in order to effect symptom reduction or behavioral change”, that the session had to be longer than 30 minutes, and that it had to be explicitly designated as a psychotherapy visit by the psychiatrist or office staff. They found that the percentage of psychotherapy visits declined from 44.4% in 1996-1997 to 28.9% in 2004-2005. Furthermore, the

number of psychiatrists who provided psychotherapy in all of their patient visits decreased from 19.1% to 1.8%, and the number who provided it to none of their patient visits increased from 24.5% to 29.2%. However, when these two extremes were removed, the association of year and percentage was no longer statistically significant, and the majority of psychiatry practices (59.4%) provided at least some psychotherapy. Additionally, they noted a robust inverse relationship between providing psychotherapy and prescribing medications. They concluded that overall, the downward trend was attributable to a decrease in psychotherapy specialists and an increase in pharmacotherapy specialists.

There may also be a shift of mental health care to other professionals. In data from the household sections of the 1987 National Medical Expenditure Survey and the 1997 Medical Expenditure Panel Survey, they found that between 1987 and 1997, percentages of patients reporting use of psychotherapy changed from approx. 48% to 65% for physicians, 32% to 35% for psychologists and 7 to 13 percent for social workers (Olfson et al. 2002). This would suggest that psychotherapy being conducted by physicians is actually increasing, but the study had several significant limitations. Those being treated by psychiatrists were not separated from other physician specialists; one recent study noted that psychiatrists only provided 73% of physician provided psychotherapy (Himelhoch and Ehrenreich 2007). Also, the survey interviewed household “informants” who were asked about all related persons living in the household (Olfson et al. 2002). As they stated in their discussion, “recall errors, stigma, and problems distinguishing psychotherapy from other health counseling pose threats to the survey data.” Also, while not mentioning what qualified as psychotherapy, they mentioned that a “broad definition” was utilized which made “it impossible to distinguish simple nonspecific support and generic counseling from established formal psychotherapies”. Another study looking at the National Comorbidity Survey Replication completed in 2003 found that of 1443 12-month cases receiving mental health treatment 30% received it from psychiatrists, 40% from non-psychiatrist mental health specialists, and 55% from general medical providers (Wang et al. 2005). While interventions used were not elucidated, non-psychiatrists treated the majority of patients. In another survey of psychiatrists, 66% of them provided at least some “medication backup” for psychotherapists despite the fact that only 38% of providers of “medication backup” found it generally ethical (Goldberg et al. 1991). Also the therapist initiated the arrangement 75% of the time.

Much has been written about the external and internal forces, such as economic, educational, scientific and philosophical, that have changed the landscape of psychiatry resulting in less psychotherapy being provided by psychiatrists (Gabbard and Kay 2001, Lieberman and Rush 1996, Kontos et al. 2006, to name a few). While treatment cost has been hypothesized as one of the strongest reasons for this shift away from the integrated model, a couple of studies have challenged this notion by reporting that treatment cost for integrated treatment being either the same or less than split treatment (Dewan 1999, Goldman et al. 1998).

Also, if providers billed for their collateral communications, a currently hidden cost to split treatment, this may influence total dollar cost. The New York State Office of Mental Health has recently enacted a clinic restructuring plan which includes collateral contacts and “complex care management” communications as billable services; although what constitutes “collateral” and “complex care management” is still defined in a limited way (New York State Office of Mental Health 2009). From a psychiatrist point of view, financial incentive is often greater for seeing four patients per hour in 15-minute “med checks” than seeing one patient per hour in integrated treatment in many financial arrangements. Opinions abound about the 15-minute “med check” both negative (Sobo 1999, Gabbard 2009, and Pies 2010) and more positive (Mossman 2010), and some clinics and psychiatrists prefer a 30-minute follow-up visit for pharmacotherapy appointments. Nevertheless, it is very likely that when considering combined treatment, many psychiatrists will be in a position of referring patients for psychotherapy to another provider in a split treatment model.

Pros and cons of the split treatment model as compared to the integrated model

Benefits of split treatment

1. Allows for increased focus and specialization of sessions, which may result in improved management of transferences and optimization of techniques (Hellerstein 2009).

2. Increased access to mental health resources (Riba and Balon 2003). In many regions of the country, there is a shortage of psychiatrists (Goldman 2001). For example, rural counties near the author’s facility in New York feel fortunate if they can attract one general psychiatrist to the region, and feel like the won the lottery if they can obtain a child psychiatrist. A split model can help maximize these limited resources, and the psychiatrist may even take on a leadership role for an entire team of therapists.

3. Increased ability to match therapist expertise with optimal psychotherapeutic techniques. Evidence is gaining supporting specialized treatments for specific disorders such as ERP for OCD, CBT or dynamic therapy for panic disorder, DBT or dynamic psychotherapy for BPD, exposure therapy for PTSD, and family supportive therapy for schizophrenia. Depending on when and where a psychiatrist trained, they may be more or less familiar with different forms of psychotherapy. The current ACGME requirements for successful completion of psychiatry residency include demonstrated competence in “applying supportive, psychodynamic, and cognitive behavioral psychotherapies to both brief and long term individual practice, as well as to assure exposure to family, couples, group and other individual evidence-based psychotherapies” (ACGME 2007). However, even if this requirement is satisfied, a psychiatrist may favor one model over another and may not feel comfortable competently delivering specific forms over time. For example, a dynamically oriented psychiatrist with an

OCD patient may want to consider using a split treatment model and refer to a therapist specializing in ERP for which a greater evidence base exists.

4. Wider variety of therapist choices (Riba and Balon 2003). Patients have greater opportunities to select therapists based on preferences such as race, ethnicity, gender or religion.

5. Increased support for clinicians and the team approach (Riba and Balon 2003, Hellerstein 2009). Ideally, the support offered by colleagues working together with patients can be helpful in moderating countertransference, dealing with crisis, improving adherence to treatment plans, coordinating vacations, and attempting to figure out complicated or treatment resistant issues. Also, working with colleagues continually challenges us to formulate and communicate our ideas clearly as well as to listen and learn from others.

Challenges of split treatment

1. Conflicts between providers. Some potential conflicts between treatment providers, especially in interdisciplinary contexts, include: clinicians not appreciating the clinical skill of the other; clinicians not agreeing with the other’s approach or conceptualization; power struggles – “Who’s in charge?” competitiveness between clinicians; and fear of being devalued by a patient or losing the patient altogether to the other (Busch and Sandberg 2007, Gould and Busch 1998, Busch and Gould 1993, Kay 2009, Goin 2001, Ellison and Harney 2000).

2. Transference and countertransference issues. For example, the patient may feel that the provider making the referral may be rejecting the patient or is too sick for their specific modality of treatment to work alone (Gould and Busch 1998, Busch and Gould 1993, Busch and Sandberg 2007, and Riba and Balon 2003). They may also idealize the new provider and correspondingly devalue the referrer as the possible strengths of the new treatment become apparent, e.g., the medications result in rapid relief of symptoms, or vice-versa, the therapist learns about detailed conflicts that may be driving the symptoms. In another example, the new pharmacotherapist “may be experienced as the authoritarian parent, the longed-for good parent that never existed, or an intrusive parent in a previously private relationship” (Goin 2001). Countertransference issues such as shame at inability to help, anger at the patient for not getting better, or “wish to be the favorite parent may encourage a therapeutically destructive power struggle with the collaborating psychotherapist” (Goin 2001), or be acted out through the referral process itself (Gould and Busch 1998, Busch and Gould 1993, Busch and Sandberg 2007, and Riba and Balon 2003). Furthermore, either provider can collude with the patient in de-idealizing the other. These issues can also be exacerbated by other natural challenges in the split treatment model, such as difficulties in inter-provider communication. Navigating these issues in patients with certain lower level personality disorders can be difficult. For example, a patient with borderline personality disorder, whose combination of splitting defense mechanisms and instability in self-image, affects and

interpersonal relationships may be too difficult to navigate in the split treatment model and may favor an integrated approach (Riba and Balon 2003).

3. Communication difficulties (Kay 2009, Riba and Balon 2003). This is probably the biggest challenge in split treatment with a multitude of factors contributing including the already above mentioned issues. Despite general recommendations in the literature to improve inter-provider communication, in one small study, 45% of psychotherapists had seen some patients who were taking medications in the past month, and of whom they have never communicated with the pharmacotherapist; and 36% said they had seen some patients for 6 months or longer without any communication with the pharmacotherapist (Avena and Kalman 2010).

4. Confusing the patient and giving the patient mixed messages. Each provider may have different formulations of the patient's difficulties – e.g., mind vs. brain, CBT vs. dynamic, etc., which can confuse the patient.

5. Legal risks – In one survey of psychiatrists, 82% believed the prescriber was legally responsible for the therapeutic behavior of the non-medical therapist and were concerned about it (Goldberg et al. 1991). “Traditionally, malpractice law has regarded physicians as having broad authority and responsibility for patient care, no matter what the physician's actual role in the treatment provided, and no matter what the levels of involvement of other professionals. The physician is considered the professional *most* responsible for overall patient care and thus bears more of the professional liability burden. Legislatures and licensing bodies have long recognized the independence of other healthcare professionals with regard to their responsibilities for patient care. The legal system has not caught up, yet” (Melonas 1999).

Tips to navigate split treatment (Goin 2001, Gabbard 2006):

1. Know the therapist treating the patient – therapeutic style, areas of expertise, how the therapist thinks about clinical issues.

2. Have a professional regard for the therapist and be aware that a therapist may have concerns regarding initiating a relationship.

3. Communicate regarding cases and have it be known to the patient from the get-go that bi-way communication with the therapist will occur. Inform patients as to the nature of discussions with the therapist. Obtain informed consent. If necessary, include communication as a billable service that can be negotiated with the patient up front or worked out with the insurance company. While few third-party payers have historically reimbursed for collateral communication, this may be changing. For example the Office of Mental Health in New York recently added a Medicaid billing code for “complex care management,” which while somewhat limited, could result in improved communication in split treatment models (New York State Office of Mental Health 2009).

4. Discuss medications with the therapist, the rationale for them, the pros/cons of prescribing them,

the time period for which one could see benefits, and the potential adverse effects. The therapist may be the first person to pick up a possible adverse effect.

5. Be attentive to manifestations of transference and countertransference. If splitting develops, such as the patient devaluing the other, a phone call may need to be made to the other provider. If very disruptive, then the two treaters may need to meet together with the patient.

6. Have clear guidelines for who the patient should call in emergency and communicate about when one or the other will be on vacation.

7. Major treatment changes should be discussed collaboratively, e.g., hospitalization.

8. Termination should be a collaborative effort – sequential vs. simultaneous.

9. Being able to formulate a patient's difficulties using different psychotherapeutic frames within the context of the pharmacotherapy appointment may help decrease patient confusion about the different treatments utilized in the split-model.

Part 3. Utilizing psychotherapeutic principles and interventions in the context of conventional pharmacotherapy appointments

“When two people meet, each one is changed by the other so you've got two new people” (Steinbeck J 1961).

Psychodynamic psychopharmacology in treatment resistance

David Mintz proposed a discipline of psychodynamic psychopharmacology (Mintz 2009, Mintz and Belnap 2006, Mintz 2005) to help conceptualize and work with treatment resistant patients. He wrote recently that the “the patient's desire to change and a positive transference to the doctor and his or her medications can mobilize profound self-healing capacities – capacities that appear to be even more potent than the medication's active ingredient” (Mintz 2009). All of the above factors, worded differently as readiness for change, therapeutic alliance and placebo effect can strongly influence treatment success or treatment resistance in either pharmacotherapy or psychotherapy treatments (Krupnick et al. 1996, Martin et al. 2000, Metz 2000, Beitman et al. 1994, Mintz 2009, Walsh et al. 2002, to name a few). Mintz suggests that psychodynamic factors may be playing a large role in treatment response and resistance, and that these factors can play out in terms of: response or lack of response to medications, sensitivity to side effects, adherence to taking medications as prescribed, and helpful or harmful transferences and countertransferences in the physician-patient relationship (Mintz 2009). He goes on to state “the effects of meaning are at least as potent as the effects of biology”. Understanding, attending to, and addressing these issues within the pharmacotherapy session may not only significantly improve your outcomes, but also increase your sense of satisfaction in working with some of the

most difficult patients.

Mintz and Belnap divided treatment resistance into two categories: those who are treatment resistant *to* medications, i.e. both conscious and unconscious factors interfere with the desired effect of the medication and enhance the undesirable effects of the medication; and those who are treatment resistant *from* medications, i.e. conscious and unconscious factors increasing one's desire for medications in spite of lack of overall benefit - while a patient in this category may seem to have improvement in symptoms, the medication does not contribute to overall improvement in quality of life (Mintz and Belnap 2006). Some examples of issues which can result in either resistance *to* or *from* medications include: ambivalence about symptom alleviation, symbolic meanings of medications leading to non-adherence, positive transference to medications leading to resistance *from* medications, and unhelpful transferences to the pharmacotherapist.

Ambivalence about symptom alleviation. In those that are treatment resistant *to* medications, patients are frequently non-adherent to the treatment regimens. One factor that may contribute to non-adherence includes underlying conscious or unconscious ambivalence about symptom alleviation. The manic patient enjoying the euphoria, the psychotic patient feeling especially important as the target of an FBI investigation, or the depressed patient fearing increased expectations if they recover, are all clear examples of how patients may be motivated to maintain their symptoms. A patient of the author recently expressed a concern that if her symptoms improved, I may not care about her as much, and may even prematurely discharge her from treatment altogether. One study found that readiness-to-change was strongly correlated with outcome in a placebo-controlled trial with a benzodiazepine in 206 patients with panic disorder (Beitman et al. 1994).

Intervention. An example intervention would be to utilize motivational interviewing techniques to explore the positive and negative aspects of the symptoms combined with the positive and negative aspects of recovery in a neutral manner; thereby making these conflicts conscious. This empowers the patient to activate their own reasoning ability to decide for themselves which side of the conflict they would like to pursue. It also helps the patient feel less shameful about their own ambivalent feelings thereby allowing them to more proactively work towards recovery as they tolerate these powerful resistive forces.

Symbolic meaning of medication leading to non-compliance. Patients may have ambivalence about taking a medication secondary to the myriad of meanings it may have for them. Themes such as dependence, sickness, chemical-imbalance, loss of control, or stigma may all lead to the patient saying "yes" in the office, but then "no" to them later (Lambert et al. *in press*). Adverse effects such as metabolic, sexual or cognitive may also have significant meaning attached, which then leads to non-adherence, even if the side effect is actually minimal. Even the awareness that these side effects exist can impact treatment, as in the case of nocebo effects.

Intervention. An example intervention could be to anticipate resistance to taking medications revolving around issues of meaning. This can result in 1) openly exploring what it is like for the patient to take, or even consider taking, medication before the issue arises; and 2) being more understanding when the situation does arise, thereby preventing a rupture in the therapeutic alliance. Utilize a therapeutic alliance model Gutheil called "participant prescribing," whereby prescribing is a collaborative relationship with "shared inquiry, shared goals, and mutual participation in both experiencing and observing the process" which emphasizes the healthy and independent adult aspects of the patient (Gutheil 1978).

Positive transference to medication leading to treatment resistance. Medications can sometimes perform defensive purposes. For example, a patient with borderline personality disorder may yearn for a medication to decrease their affective arousal, and while it may be temporarily relieving, it may also hinder their ability to learn how to tolerate their emotional experiences, which eventually impairs their ability to recover from their disorder (Gregory accessed August 2010). Medications may also provide a vehicle for not owning and taking responsibility for their conflicts, feelings and actions, "if you don't give me something for this anger, I will hurt someone" (Mintz and Belnap 2006, Gregory accessed August 2010).

Intervention. A possible intervention for this would be to support the concerns they have over the severity of their powerful affects and urges. It may help to discuss with the patient that while a medication may temporarily take the edge off the symptom, it may delay their overall progress; and that, while learning to tolerate their emotions is challenging, they do have the capability to change their behavioral responses to these strong feelings in the future, and that with practice they will likely get better at it. Also, offering one of the evidence based psychotherapeutic treatments for these disorders such as dialectical behavioral therapy, mentalization based therapy, transference focused therapy or dynamic deconstructive psychotherapy provides hope and a definite plan to help relieve their distress.

Transference to the psychiatrist when medications are prescribed or not prescribed. Gutheil discussed examples of both positive and negative transference to the psychiatrist who either prescribes or refuses to prescribe (or change) a medication (Gutheil 1982, 1978). Prescribing medication may be seen as an empathic, responsive, caring, validating, and giving act - Gutheil gave an example of a patient who said, "If you really thought I was sick, you would be giving me medications". Conversely, patients may feel just the opposite. Prescribing may be seen as their struggles and suffering being dismissed, minimized or invalidated - Gutheil gave an example of a patient who said, "when my previous therapist took out his prescription pad, I knew I could never tell him anything important." They may also feel blamed for their problems, as if their struggles were in their own head, and not related to the

difficult life circumstances they have been handed. This may reinforce attitudes that if only they were stronger or better people they could handle what was going on in their lives. They may also feel the prescriber is attempting to control them; as Gutheil stated, an “imperious demand to get better” or “demand that the patient surrender his symptoms, his illness, or the caretaking environment”. A more paranoid patient may even feel the prescriber is trying to cause harm. In the opposite situation, a positive transference to a psychiatrist who refuses to prescribe medication may come as Gutheil wrote, a “vote of confidence in the patient and the psychotherapeutic process.” Alternatively, the patient may react negatively to refusing to prescribe in that it may be viewed as an act of withholding treatment, which renders the psychiatrist as uncaring, sadistic, and not willing to help. It may also be seen as not taking the patient’s struggles seriously or as thinking the patient is exaggerating their symptoms. In conclusion, even though medications are studied in patients meeting standardized descriptive diagnostic criteria, the dynamic heterogeneity and resulting varied transferences to psychiatrists in patients is quite remarkable and may affect the medication’s efficacy.

Intervention. An example intervention when dealing with transference to the pharmacotherapist that may be interfering with treatment is to bring it out into the open and explore it together so that a collaborative relationship can be restored. For example, “I noticed a shift in your facial expression when I just made that recommendation. What was it like for you to hear that?” (Gregory accessed August 2010).

Also, attending to and containing countertransference is important as well. Some signals that countertransference may be at work include: 1) feeling engaged in a power struggle; 2) feeling a sudden onset of dysphoric emotions which may have been evoked by a patient’s own strong dysphoric affect; or 3) feeling a strong urge to act in a particular way (Mintz and Belnap 2006).

1) Removing oneself from a power struggle by openly bringing up the double bind that one feels in helps to alleviate the tension and challenge the notion that you want to control them. For example, “On the one hand, I can appreciate the level of distress you are in and would like to prescribe a medication that may help relieve it, but on the other, I can also appreciate your concerns about taking medications and that you may not be interested in taking one at this time” (Gregory accessed August 2010).

2) When feeling a sudden onset of dysphoric emotion, asking the patient about any dysphoric emotions they may be experiencing may help them put words to it, decrease the countertransference, and decrease the risk of countertransference based prescribing (Mintz and Belnap 2006, Gregory accessed August 2010).

3) When feeling a sudden strong or impulsive urge to act in any particular way, abstaining from action helps prevent countertransference based prescribing, which will not only be unhelpful, but may actually be harmful (Mintz and Belnap 2006, Gregory accessed August

2010). Countertransference based prescribing can increase the overall adverse effect risk, further prevent the patient from obtaining optimal treatment, and further entrench the transference which led to the countertransference based reaction in the first place. For example, a patient may feel such a strong internal sense of badness that while they may feel the prescriber is noble and heroic, they may also feel the prescriber is powerless to help them (Gregory accessed August 2010). This may induce countertransference-based feelings of helplessness combined with a strong urge to rescue the patient; attempts at which will inevitably fail and therefore eventually confirm the patient’s initial hypothesis and increase their sense of hopelessness – “even my amazing psychiatrist can’t help me”. Feelings of helplessness in the prescriber can be an especially potent trigger for a whole range of countertransference-based emotions such as guilt, anger or frustration. These emotions can hijack the unsuspecting prescriber and result in a range of unhelpful countertransference-based behaviors such as rescuing, rejecting, or pacifying. Learning to tolerate these powerful countertransference-based emotions and urges is not only fruitful for the patients, but is also helpful for the mental health of the provider.

Optimizing physician-patient relatedness to improve outcome

Moving between three models of physician-patient relatedness. Szasz and Hollender (1956) conceptualized three basic models for the physician-patient relationship: 1) Active-Passivity – in which the “physician does something to the patient”; surgeries, coma, delirium, etc... Physician is active and the patient is passive – appropriate for emergencies in which the patient is no longer competent, such as catatonic depression, severe mania or psychosis – similar to parent-infant model. 2) Guidance-Cooperation – most common model in medicine - physician tells the patient what to do, and the patient cooperates. Both parties are active in that a competent patient actively seeks help from a physician, and in turn agrees to cooperate with the physician’s advice – similar to parent-adolescent model in that the patient is expected to obey doctor’s orders. It works well in non-emergent, yet acute illnesses such as infections or initial treatment of panic attacks. 3) Mutual Participation – physician helps the patient to help himself, and the patient primarily carries out the treatment program utilizing the physician as an expert consultant or advisor - similar to an adult-adult model. This model is more helpful in chronic illnesses such as diabetes, chronic heart disease, and many psychiatric conditions where patients make more complex behavioral and psychological changes in order to influence either health or disease processes.

While collaborative and “participant prescribing” relationships, which are akin to Szasz and Hollender’s mutual-participation model, are frequently purported to be most helpful in optimizing therapeutic alliance in psychiatry (ex: Gutheil 1978, Metzl 2000, Szasz and Hollender 1956), the reality is that all 3 physician-patient models are useful in different circumstances. We are challenged not only to satisfactorily employ

them all when necessary, but also to successfully transition both ourselves and the patient between them as the clinical situation dictates, always working towards providing the highest level of patient autonomy possible. These transitions are fraught with potential for rupture of the therapeutic alliance, significant transference and countertransference, and inappropriate or insufficient care being delivered. For example, a psychiatrist who efficiently manages a grossly manic and psychotic patient in the ER may struggle as the patient, later seen in outpatient practice, successfully maintains euthymia and begins to challenge the psychiatrist on what it means to be effectively treated – i.e. what medication side effects he is willing to tolerate, and how best to proceed in the future. If the psychiatrist does not adjust to a more collaborative model, a rupture in the therapeutic alliance is likely to occur which could precipitate a decrease in medication adherence thereby increasing risk for relapse. Alternatively, the patient may transfer himself to another provider. In the former case, the psychiatrist can use the “I told you so” mantra to initially re-commit the patient to treatment, but at the risk of continuing to thwart the therapeutic alliance as the patient’s autonomy continues to be undermined. Conversely, if clinically indicated, one may also have to transition to more authoritative models. This can be equally challenging to navigate as it may result in rupture of the therapeutic alliance, which then needs to be attended to and repaired. For example, as a new third year resident just beginning to learn psychotherapy, I had been working with a depressed patient for several months and came to respect her intelligence and individuality. She was wary of medications and was interested in other ways to address her symptoms, which given my budding passion for psychotherapy, I enthusiastically embraced. However, when she began showing signs of mania, I failed to timely transition from the mutual-participation model to more authoritative models as the clinical situation dictated. While she thankfully did not get into any serious trouble, I lost much sleep and probably gained some gray hair as I painstakingly worked to help her become euthymic while assessing safety through many visits and phone calls in the outpatient setting. Those familiar with mania know how lucky I was that the only thing that both the patient and I lost was sleep. If I had been able to switch to a guidance-cooperation model more quickly, the risks may have been decreased.

Mind-Brain Split and physician-patient relatedness. Kandell said it simply - “All functions of mind reflect functions of brain” (Kandell 1998). Historically, approaches to treatment were often dichotomized into psychotherapy as a treatment for “psychologically based” disorders and medications as a treatment of “biologically based disorders” (Gabbard 2000). However, as a recent popular psychiatry textbook notes, “dualistic theories separating mind and brain are being replaced by more integrated models with increasing evidence that psychotherapy influences brain functioning and pharmacology influences the mind” (Szigethy and Friedman 2009). Therefore this author will assume acceptance of an integrated conceptualization of mind and brain, and if not, the reader is directed to reviews of the integration of mind and brain

and the neurobiology of psychotherapy (Andreasen 1997, Kandel 1998, Liggan and Kay 1999, Gabbard GO 2000, Blinder 2003).

However, even if the pharmacotherapist is in full agreement with the integrated argument, the mind-brain split continues to challenge the provider’s relatedness to the patient, and hence challenges the collaborative therapeutic alliance. Gutheil discussed how psychiatrists may unwittingly switch models in an anti-therapeutic manner, something he called the ‘mind-brain barrier’ – a tendency on the part of clinicians to ‘shift gears’ in a marked manner when contemplating the use of medications in a psychotherapeutic context (Gutheil 1982). He noted that physicians shifted to an “authoritarian posture” and “the same physicians who adopt a receptive, open posture toward their patients’ verbal productions may take a rigid, prescriptive stance in relation to drugs, offering direct and specific suggestions, even commands, which they would energetically eschew in the psychotherapeutic interaction”. He thought psychiatrists may view medications as having the virtues of concreteness, specificity, precision, and straightforwardness, that he termed “the delusion of precision”. Also, the psychiatrist’s identity may be related to the medications he prescribes: “Telling a doctor his pills aren’t working is like telling a mother her baby is ugly”. He notes that the problem with this stance, is that it may evoke complimentary passivity in the patient, “the posture of compliance”, which he felt emphasized the patient’s weaknesses in assuming a dependent sick role, and not consistent with the more ideal model he proposed, ‘participant prescribing’.

Gutheil suggests that switching between psychotherapy and pharmacotherapy stances may lead to switching from Szasz and Hollender’s mutual-participation model to the guidance-cooperation model, and proposes that this switch is not helpful. However, as noted above, there are times in which neurobiology may dictate that one switch into a more authoritarian model, and that not switching may be perilous.

Docherty originally proposed the idea of “bimodal relatedness,” which explored the “complex form of relatedness that the psychiatrist must establish with the patient” (Docherty et al. 1977). He proposed that psychiatrists needed to oscillate between relating to the patient as “diseased organ,” or “subject-object mode,” and relating to the patient as “disturbed person,” or “subject-subject mode.” In subject-object mode, the psychiatrist focuses on the neurobiological system and attempts to “act on it” to enact change. In subject-subject mode, the psychiatrist focuses on the psychosocial aspects and recognizes “the patient as an independent other with an autonomous subjectivity” (Docherty et al. 1977). Docherty also noted that “the simultaneous maintenance of these two forms of relatedness imposes a difficult strain and elicits a predictable desire to simplify matters”. Neither mode of relatedness can be abandoned. Eliminating the subject-subject pole is expressed by complaints from patients who feel that physicians treat them only as the “case of appendicitis down the hall”. It also removes the collaborative physician-patient relationship as a possibility as it requires subject-subject relatedness. Eliminating the subject-object pole ignores what

medications actually do, which is to act directly on the neurobiology, which only indirectly affects the psychosocial sphere. The subject-subject mode also fails to appreciate how the neurobiology can affect one's ability to function as an independent and autonomous other, such as in severe psychosis; that at times it will be necessary to "act on" the neurobiology and relate more in the subject-object mode. Thus the "bimodal relatedness" model is useful in that, as Sandberg states, it "focuses on an irreducible and inevitable tension between these different modes of relating" and that it is important "to have the capacity to oscillate, when indicated, between pharmacological and psychotherapeutic modes of relating" (Sandberg 1998), which as both Busch and Sandberg write, "expresses the distinction between being with a patient and acting on a patient" (2007). Furthermore, the "bimodal relatedness" model can provide a biopsychosocial framework for helping providers proactively transition between Szasz and Hollender's three models of physician-patient relationships.

Recognizing Szasz and Hollender's three models for physician-patient relationships and Docherty's model of 'bimodal relatedness,' and the natural tensions that develop, decreases physician confusion as to the most appropriate therapeutic stance in any particular situation. It also increases comfort in making any necessary transitions. These models help physicians anticipate both the positive and negative effects these modes of relatedness can have on therapeutic alliance, to take steps to prepare the patient in advance for any difficulties, and to attend to repairing any therapeutic ruptures should they occur. Lastly, they inform us that having a therapeutic rupture as a result of these natural tensions does not necessarily mean a mistake was made or inadequate care delivered. Knowing this eases the process of attending to these ruptures.

To summarize, when facing treatment resistance in the context of pharmacotherapy, asking and addressing the following questions may be a means of not only increasing the likelihood of remission, but also preventing unnecessary medication changes and saving, what can sometimes amount to be, an enormous amount of time, resources and frustration:

- 1) Could the patient be ambivalent about symptom alleviation? And if so, what is the nature of this ambivalence?
- 2) Could the patient be experiencing any positive or negative transference to either the medications or my prescribing practices that may be interfering with treatment? And if so, are there any associated countertransference behaviors that I am engaging in which could be interfering as well?
- 3) What is my mode of relatedness to the patient? And is it optimized to the clinical situation? If not, then what is preventing me from shifting to the most efficacious stance?"

Other important atheoretical factors in therapeutic alliance

Ackerman and Hilsenroth reviewed the personal attributes and techniques that facilitated a positive

psychotherapeutic alliance (2003). Personal attributes that most strongly facilitated psychotherapeutic alliance included being flexible, experienced, trustworthy, honest, respectful, confident, interested, enthusiastic, alert, friendly, warm and open. Techniques that most strongly facilitated psychotherapeutic alliance included clear communication, exploration, depth, reflection, supportive, notes past therapy success, accurate interpretation, facilitates expression of affect, enthusiasm, active, involved, affirming, understanding, and attends to patient's experience. Theoretical orientation did not correlate with a positive influence on alliance. They also noted that the factors related to facilitating positive alliance were similar to those identified in dealing with repair of ruptures in alliance. Of note, several of the above factors, are considered to be important elements of empathy and important elements demonstrating the therapist's investment in the relationship. This serves as a reminder that investing in fundamental basic interpersonal attributes and skills is invaluable in treating patients effectively.

Utilizing psychotherapeutic interventions based on formal psychotherapy models within the context of the pharmacotherapy appointment

Patients commonly present with distressing concerns that may not need a formal trial of medication or psychotherapy, but may respond to even very brief within-session psychotherapeutic interventions. Interventions and formulations within any model of psychotherapy, such as psychodynamic, CBT, IPT, supportive, or otherwise can prove very helpful at times. Some examples include helping patients understand the normal grief process, providing supportive interventions after a patient loses a job, educating patients on exposure based techniques for subsyndromal panic or OCD symptoms that they can utilize on their own, providing a dynamic interpretation for a new and sudden onset of a symptom, or helping a child work through their encopresis using brief CBT techniques. Sometimes, even the formulation itself is helpful. For example, providing a CBT formulation for a depressed patient can be accomplished in a brief period of time, and can help set the patient up to begin noticing and challenging cognitive distortions, and begin to think about how they can modulate either their thoughts or behaviors to change their mood. These interventions can be especially helpful to the patient if referral to a therapist is pending.

Conclusions

Psychotherapy can be a valuable asset to pharmacotherapy practice. Whether prescribing psychotherapy along with medications, optimizing split-treatment, integrating the treatments, or utilizing psychotherapeutic principles and techniques within one's pharmacotherapy practice; learning about the different psychotherapies and their underlying principles can be extremely helpful. It is often felt that psychotherapy is less risky, should be used frontline

and in mildly impaired patients, but the author would suggest that psychotherapy can be used after medications fail to gain remission and even after treatment resistance is highly developed. Psychopharmacologists must be ready and willing to see, even in the fast paced world of the ten-minute medication management session, that psychotherapeutic processes are happening and when addressed, better adherence and outcomes may result.

Psychotherapy not only teaches us about developing core skills and personal attributes such as empathy and warmth that are highly correlated with positive therapeutic alliance. It also teaches us how to negotiate the very real and inevitable speed bumps which disrupt alliance in psychopharmacological practice and contributes to treatment resistance such as: transference and countertransference, the natural tension between mind and brain, and the unique meanings patients bring to their symptoms, medications, and recovery.

References

- Accreditation Council for Graduate Medical Education (2007). *ACGME Program Requirement for Graduate Medical Education in Psychiatry*. Last updated July, 2009. From http://www.acgme.org/acWebsite/downloads/RRC_progReq/400_psychiatry_07012007_u04122008.pdf
- Ackerman SJ , Hilsenroth MJ (2003). A review of therapist characteristics and techniques positively impacting the therapeutic alliance. *Clinical Psychology Review* 23, 1-33.
- Andreasen NC (1997). Linking mind and brain in the study of mental illnesses: A project for a scientific psychopathology. *Science* 275, 5603, 1586-1593.
- Avena JA , Kalman TP (2010). Provider communication in split treatment: A survey. *Psychiatric Services* 61, 7, 729.
- Beitman BD, Beck NC, Deuser WE, Carter CS, Davidson JRT and Maddock RJ (1994). Patient stage of change predicts outcome in a panic disorder medication trial. *Anxiety* 1, 2, 64-69.
- Berg AO, Breslau N, Goodman S, et al. [Committee on Treatment of Post Traumatic Stress Disorder] (2007). *Institute of Medicine: Treatment of PTSD: An Assessment of the Evidence*. Washington, DC, National Academies Press. From <http://www.iom.edu/Reports/2007/Treatment-of-PTSD-An-Assessment-of-The-Evidence.aspx>.
- Blanco C, Heimberg RG, Schneier FR, Fresco DM, Chen H, et al. (2010). A Placebo-Controlled Trial of Phenelzine, Cognitive Behavioral Group Therapy, and Their Combination for Social Anxiety Disorder. *Archives of General Psychiatry* 67, 3, 286-295.
- Blinder BJ (2003). Psychodynamic neurobiology. In Beitman BD, Blinder BJ, Thase ME, Riba M, and Safer DL (Eds) *Integrating Psychotherapy and Pharmacotherapy: Dissolving the Mind-Brain Barrier*. W.W. Norton and Company, New York, NY.
- Blomhoff S, Haug TT, Hellström K, Humble HM, Madsbu HP and Wold JE (2001). Randomized controlled general practice trial of sertraline, exposure therapy and combined treatment in generalized social phobia. *British Journal of Psychiatry* 179, 21-30.
- Busch FN, Gould E (1993). Treatment by a psychotherapist and a psychopharmacologist: Transference and countertransference issues. *Hospital and Community Psychiatry* 44, 8, 772-774.
- Busch FN, Sandberg LS (2007). *Psychotherapy and Medication: The Challenge of Integration*. The Analytic Press, Taylor and Francis Group, New York, NY.
- Ciechanowski PS, Katon WJ, Russo JE, Walker EA (2001). The patient-provider relationship: attachment theory and adherence to treatment in diabetes. *American Journal of Psychiatry* 158, 1, 29-35.
- Cuijpers P, van Straten A, Warmerdam L, and Andersson G (2009a). Psychotherapy versus the combination of psychotherapy and pharmacotherapy in the treatment of depression: A meta-analysis. *Depression and Anxiety* 26, 3, 279-288.
- Cuijpers P, Dekker J, Hollon SD, and Andersson G (2009b). Adding psychotherapy to pharmacotherapy in the treatment of depressive disorder in adults: A meta-analysis. *Journal of Clinical Psychiatry* 70, 9, 1219-1229.
- Davidson RT, Foa EB, Huppert JD, Keefe FJ, Franklin ME et al. (2004) Fluoxetine, Comprehensive Cognitive Behavioral Therapy, and Placebo in Generalized Social Phobia. *Archives of General Psychiatry* 61, 1005-1013.
- Dewan M (1999). Are psychiatrists cost-effective? An analysis of integrated versus split treatment. *American Journal of Psychiatry* 156, 2, 324-326.
- Docherty JP, Marder SR, Kammen DPV, and Siris SG (1977). Psychotherapy and pharmacotherapy: Conceptual issues. *American Journal of Psychiatry* 134, 5, 529-533.
- Dowd SM , Janicak PG (2009). *Integrating Psychological and Biological Therapies*. Lippincott Williams and Wilkins, Philadelphia, PA.
- Ellison JM , Harney PA (2000). Treatment-resistant depression and the collaborative treatment relationship. *Journal of Psychotherapy Practice and Research* 9, 1, 7-17.
- Foa EB, Liebowitz MR, Kozak MJ, Davies S, Campeas R, et al. (2005). Randomized, placebo-controlled trial of exposure and ritual prevention, clomipramine, and their combination in the treatment of obsessive-compulsive disorder. *American Journal of Psychiatry* 162, 1, 151-161.
- Friedman MA, Detweiler-Bedell JB, Leventhal HE, Horne R, Keitner GI, and Miller IW (2004). Combined psychotherapy and pharmacotherapy for the treatment of major depressive disorder. *Clinical Psychology: Science and Practice* 11, 1, 47-68.
- Friedman ES , Thase ME (2009). Combining cognitive-behavioral therapy with medication. In Gabbard GO (Ed) *Textbook of Psychotherapeutic Treatments*. American Psychiatric Publishing, Arlington, VA. From <http://psychiatryonline.com>
- Furukawa TA, Watanabe N, and Churchill R (2007). Combined psychotherapy plus antidepressants for panic disorder with or without agoraphobia. *Cochrane Database of Systematic Reviews* Issue 1, Art.No.:CD004364. DOI: 10.1002/14651858.CD004364.pub2. From <http://www.thecochranelibrary.com>.
- Gabbard GO (2000). A neurobiologically informed perspective on psychotherapy. *British Journal of Psychiatry* 177, 117-122.
- Gabbard GO (2009). Deconstructing the “med check.” *Psychiatric Times*. From: <http://www.psychiatric-times.com/display/article/10168/1444238>.
- Gabbard GO , Kay J (2001). The fate of integrated treatment: What happened to the biopsychosocial psychiatrist? *American Journal of Psychiatry* 158, 12, 1956-1963.
- Goin MK (2001). Split Treatment: The Psychotherapy Role of the Prescribing Psychiatrist. *Psychiatric Services* 52, 5, 605-609.
- Goldberg RS, Riba M, Tasman A (1991). Psychiatrists' attitudes towards prescribing medications for patients treated by nonmedical psychotherapists. *Hospital and Community Psychiatry* 42, 3, 276-280.
- Goldman W (2001). Is There a Shortage of Psychiatrists? *Psychiatric Services* 52, 12, 1587-1589.
- Goldman W, McCulloch J, Cuffel B, Zarin DA, Suarez A, and Burns BJ (1998). Outpatient utilization patterns of integrated and split psychotherapy and pharmacotherapy for depression. *Psychiatric Services* 49, 4, 477-482.

- Gould E, Busch FN (1998). Therapeutic triangles: some complex clinical issues. *Psychoanalytic Inquiry* 18, 5, 730-745.
- Gregory RJ (Accessed August 2010). Remediation for treatment-resistant borderline personality disorder: Manual of dynamic deconstructive psychotherapy. From http://www.upstate.edu/psych/education/psychotherapy/pdf/ddp_manual.pdf
- Gutheil TG (1982). The psychology of psychopharmacology. *Bulletin of the Menninger Clinic* 46, 4, 321-330.
- Gutheil TG (1978). Drug therapy: Alliance and compliance. *Psychosomatics* 19, 4, 219-225.
- Hellerstein DJ (2009). Combining supportive psychotherapy with medication. In Gabbard GO (Ed) *Textbook of Psychotherapeutic Treatments*. American Psychiatric Publishing, Arlington, VA. From <http://psychiatryonline.com>
- Himelhoch S, Ehrenreich M (2007). Psychotherapy by primary-care providers: Results of a national sample. *Psychosomatics* 48, 4, 325-330.
- Hollon SD, Jarrett RB, Nierenberg AA, Thase ME, Trivedi M, and Rush AJ (2005). Psychotherapy and medication in the treatment of adult and geriatric depression: Which monotherapy or combined treatment? *Journal of Clinical Psychiatry* 66, 4, 455-468.
- Kandel ER (1998). A new intellectual framework for psychiatry. *American Journal of Psychiatry* 155, 4, 457-469.
- Kay J (2009). Combining psychodynamic psychotherapy with medication. In Gabbard GO (Ed.), *Textbook of Psychotherapeutic Treatments*. American Psychiatric Publishing, Arlington, VA. From <http://psychiatryonline.com>
- Kontos N, Querques J, and Freudenreich O (2006). The problem of the psychopharmacologist. *Academic Psychiatry* 30, 3, 218-226.
- Krupnick JL, Sotsky SM, Elkin I, Simmens S, Moyer J, Watkins J and Pilkonis PA (1996). The role of the therapeutic alliance in psychotherapy and pharmacotherapy outcome: Findings in the National Institute of Mental Health Treatment of Depression Collaborative Research Program. *Journal of Consulting and Clinical Psychology* 64, 3, 532-539.
- Lambert BL, Levy NA, Winer J (in press). Keeping the balance and monitoring the self-system: towards a more comprehensive model of medication management in psychiatry. In Brashers D and Goldsmith D (Eds) *Communication and the Management of Health and Illness*. Erlbaum, New Jersey. From http://tigger.uic.edu/~lambertb/con_pres/Comprehensive_Me_%20Mgmt.pdf.
- Lieberman JA, Rush AJ (1996). Redefining the role of psychiatry in medicine. *American Journal of Psychiatry* 153, 11, 1388-1397.
- Liggan DY, Kay J (1999). Some neurobiological aspects of psychotherapy: A Reivew. *The Journal of Psychotherapy Practice and Research* 8, 2, 103-114.
- Martin DJ, Garske JP, and Davis MK (2000). Relation of the therapeutic alliance with outcome and other variables: a meta-analytic review. *Journal of Consulting and Clinical Psychology* 68, 3, 438-450.
- Mellman L, Beresin E (2003). Psychotherapy Competencies: Development and Implementation. *Academic Psychiatry* 27, 149-153.
- Melonas JM (1999). Split treatment: Does managed care change the risk in psychiatry. *Psychiatric Practice and Managed Care Newsletter* 5, 3.
- Metzl JM (2000). Forming an effective therapeutic alliance. In Tasman A, Riba MB and Silk KR (Eds.), *The Doctor-Patient Relationship in Pharmacotherapy*. The Guilford Press, New York, NY.
- Mintz D (2009). Psychodynamic psychopharmacology: Addressing the underlying causes of treatment resistance [Electronic Edition]. *Psychiatric Times* 26, 8, 1-6.
- Mintz DL (2005). Teaching the prescriber's role: The psychology of psychopharmacology. *Academic Psychiatry* 29, 2, 187-194.
- Mintz D, Belnap B (2006). A view from Riggs: Treatment resistance and patient authority – III. What is psychodynamic psychopharmacology? An approach to pharmacologic treatment resistance. *Journal of the American Academy of Psychoanalysis and Dynamic Psychiatry* 34, 4, 581-601.
- Mojtabai R, Olfson M (2008). National trends in psychotherapy by office-based psychiatrists. *Archives of General Psychiatry* 65, 8, 962-970.
- Mossman D (2010). Successfully navigating the 15-minute 'med check.' *Current Psychiatry* 9, 6, 40-43.
- New York State Office of Mental Health (2009). Clinic restructuring implementation plan. From http://www.coalitionny.org/news_resources/briefs/2009/documents/2009-3-11OMHfinalclinicrestructuringimplementationpaper.pdf
- Olfson M, Marcus SC, Druss B, and Pincus HA (2002). National trends in the use of outpatient psychotherapy. *American Journal of Psychiatry* 159, 11, 1914-1920.
- Pampalona S, Bollini P, Tibaltd G, Kupelnick B and Munizza C (2004). Combined Pharmacotherapy and Psychological Treatment for Depression. *Archives of General Psychiatry* 61, 7, 714-719.
- Pediatric OCD Treatment Study (POTS) Team (2004). Cognitive-behavior therapy, sertraline, and their combination for children and adolescents with obsessive-compulsive disorder: The pediatric OCD treatment study (POTS) randomized controlled trial. *Journal of the American Medical Association* 292, 16, 1969-1976.
- Pies RW (2010). Psychiatrists, physicians, and the prescriptive bond. *Psychiatric Times* From <http://www.psychiatristimes.com/blog/couchincrisis/content/article/10168/1555057>
- Riba MB, Balon R (2003). The challenges of split treatment. In Beitman BD, Blinder BJ, Thase ME, Riba M, Safer DL (Eds) *Integrating Psychotherapy and Pharmacotherapy: Dissolving the Mind-Brain Barrier*. W.W. Norton and Company, New York, NY, 141-160.
- Riba MB, Balon R (2008). Combining psychotherapy and pharmacotherapy. In Hales RE, Yudofsky SC, Gabbard GO (Eds) *The American Psychiatric Publishing Textbook of Clinical Psychiatry*, 5th ed. American Psychiatric Publishing, Arlington, VA. From <http://psychiatryonline.com>.
- Rutherford BR, Cabaniss DL, Roose SP (2008). Combined treatment with medications and psychotherapy. In Tasman A, Kay J, Lieberman JA, First MB and Maj M (Eds) *Psychiatry*, 3rd ed. John Wiley and Sons, Hoboken, NJ.
- Sandberg L (1998). Analytic listening and the act of prescribing medication. *Psychoanalytic inquiry* 18, 621-638.
- Simpson HB, Foa EB, Liebowitz MR, Ledly DR, Huppert JD et al. (2008). A randomized, controlled trial of cognitive-behavioral therapy for augmenting pharmacotherapy in obsessive-compulsive disorder. *American Journal of Psychiatry* 165, 5, 621-630.
- Smith EG, Mathur A (2006). Blinding in psychotherapy plus medication trials. *American Journal of Psychiatry* 163, 7, 1295.
- Sobo S (1999). Psychotherapy perspectives in medication management: the inadequacy of 15-min med checks as standard psychiatric practice. *Psychiatric Times* 16, 4. From <http://www.psychiatristimes.com/display/article/10168/50241>.
- Steinbeck J (1961). *The Winter of Our Discontent*. The Viking Press, New York, NY.
- Szasz TS, Hollender MH (1956). A Contribution to the Philosophy of Medicine: The basic models of the doctor-patient relationship. *A.M.A. Archives of Internal Medicine* 97, 5, 585-592.
- Szigethy EM, Friedman ES (2009). Combined psychotherapy and pharmacology. In Sadack BJ, Sadock VA, Pedro R (Eds) *Kaplan and Sadock's Comprehensive Textbook of Psychiatry*, 9th ed. Lippincott Williams and Wilkins, Philadelphia, PA.

- Tasman A (2002). Lost in the DSM-IV checklist: Empathy, meaning, and the doctor-patient relationship. *Academic Psychiatry* 26, 1, 38-44.
- Thase ME, Greenhouse JB, Frank E, Reynolds CF III, Pilonis PA, Hurley K, Grochocinski V and Kupfer DJ (1997). Treatment of major depression with psychotherapy or psychotherapy-pharmacotherapy combinations. *Archives of General Psychiatry* 54, 11, 1009-1015.
- Thase ME (2003). Conceptual and empirical basis for integrating psychotherapy and pharmacotherapy. In Beitman BD, Blinder BJ, Thase ME, Riba M, and Safer DL (Eds) *Integrating Psychotherapy and Pharmacotherapy: Dissolving the Mind-Brain Barrier*. W.W. Norton and Company, New York.
- Treatment for Adolescents with Depression Study (TADS) Team (2009). The treatment for adolescents with depression study (TADS): Outcomes over 1 year of naturalistic follow-up. *American Journal of Psychiatry* 166, 10, 1141-1149.
- Vesga-López O and Blanco C (2009). Combining interpersonal psychotherapy with medication. In Gabbard GO (Ed) *Textbook of Psychotherapeutic Treatments*. American Psychiatric Publishing, Arlington, VA. From <http://psychiatryonline.com>
- Walsh BT, Seidman SN, Sysko R, Gould M (2002). Placebo response in studies of major depression: Variable, substantial and growing. *Journal of the American Medical Association* 287, 14, 1840-1847.
- Watanabe N, Churchill R, Furukawa TA (2009). Combined psychotherapy plus benzodiazepines for panic disorder. *Cochrane Database of Systematic Reviews* Issue 1, Art. No.: CD005335. DOI: 10.1002/14651858.CD005335.pub2. From <http://www.thecochranelibrary.com>.
- Wilk JE, West JC, Rae DS and Regier DR (2006). Patterns of adult psychotherapy in psychiatric practice. *Psychiatric Services* 57, 4, 472-476.
- Wright J , Hollifield M (2006). Combining pharmacotherapy and psychotherapy. *Psychiatric Annals* 36, 5, 302-305.
- Yager J, Ninninger JE and Anzia DJ, et al. [APA steering committee on practice guidelines] (2005a). Treatment of patients with borderline personality disorder. *American Psychiatric Association Practice Guidelines for the Treatment of Psychiatric Disorders: Compendium 2006*. American Psychiatric Publishing, Inc. Arlington, VA. From <http://psychiatryonline.com>
- Yager J, Ninninger JE and Anzia DJ, et al. [APA steering committee on practice guidelines] (2005b). Treatment of patients with major depressive disorder, 2nd ed. *American Psychiatric Association Practice Guidelines for the Treatment of Psychiatric Disorders: Compendium 2006*. American Psychiatric Publishing, Inc. Arlington, VA. From <http://psychiatryonline.com>
- Yager J, Ninninger JE and Anzia DJ, et al. [APA steering committee on practice guidelines] (2005c). Treatment of patients with bipolar disorder, 2nd ed. *American Psychiatric Association Practice Guidelines for the Treatment of Psychiatric Disorders: Compendium 2006*. American Psychiatric Publishing, Inc. Arlington, VA. From <http://psychiatryonline.com>
- Yager J, Ninninger JE and Anzia DJ, et al. [APA steering committee on practice guidelines] (2006). Treatment of patients with eating disorders, 3rd ed. *American Psychiatric Association Practice Guidelines for the Treatment of Psychiatric Disorders: Compendium 2006*. American Psychiatric Publishing, Inc. Arlington, VA. From <http://psychiatryonline.com>
- Yager J, Ninninger JE and Anzia DJ, et al. [APA steering committee on practice guidelines] (2007a). Treatment of patients with substance use disorders, 2nd ed. *American Psychiatric Association Practice Guidelines for the Treatment of Psychiatric Disorders: Compendium 2006*. American Psychiatric Publishing, Inc. Arlington, VA. From <http://psychiatryonline.com>.
- Yager J, Ninninger JE and Anzia DJ, et al. [APA steering committee on practice guidelines] (2007b). Treatment of patients with obsessive-compulsive disorders. *American Psychiatric Association Practice Guidelines for the Treatment of Psychiatric Disorders: Compendium 2006*. American Psychiatric Publishing, Inc. Arlington, VA. From <http://psychiatryonline.com>.
- Yager J, Ninninger JE and Anzia DJ, et al. [APA steering committee on practice guidelines] (2009a). Treatment of patients with panic disorder, 2nd ed. *American Psychiatric Association Practice Guidelines for the Treatment of Psychiatric Disorders: Compendium 2006*. American Psychiatric Publishing, Inc. Arlington, VA. From <http://psychiatryonline.com>
- Yager J, Ninninger JE and Anzia DJ, et al. [APA steering committee on practice guidelines] (2009b). Treatment of patients with acute stress disorder and post traumatic stress disorder. *American Psychiatric Association Practice Guidelines for the Treatment of Psychiatric Disorders: Compendium 2006*. American Psychiatric Publishing, Inc. Arlington, VA. From <http://psychiatryonline.com>
- Yager J, Ninninger JE and Anzia DJ, et al. [APA steering committee on practice guidelines] (2009c). Treatment of patients with schizophrenia, 2nd ed. *American Psychiatric Association Practice Guidelines for the Treatment of Psychiatric Disorders: Compendium 2006*. American Psychiatric Publishing, Inc. Arlington, VA. From <http://psychiatryonline.com>