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INTEGRATED CO-THERAPY:

COLLABORATION BETWEEN A PSYCHIATRIST AND A NON-PSYCHIATRIC THERAPIST

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History of the Co-Therapeutic Model

1) Over the past 30+ years, there has been a powerful shift in paradigms regarding provision of psychotherapy and psychopharmacological intervention

    A) Classical (psychoanalytic) theory frowned upon a "split-therapy" model
        i. Practical/professional issues and "turf battles"
        ii. Concerns regarding "splitting the transference"

2) Gradually, as non-psychiatric practitioners appreciated that many patients could benefit from psychopharmacological intervention along with psychotherapeutic intervention, psychiatric consultation came into vogue as an accepted form of treatment

    A) Early on, there was no one clear protocol regarding how therapy should be conducted making use of two mental health professionals
    B) Psychiatrists gradually moved into more of a "consulting" role, but usually with a collaboration of effort and integration of diagnostic understanding and treatment overall approaches
    C) With time, psychiatrists tended to focus more exclusively on prescription of medications

3) Currently, many psychiatrists take a completely "biological" role
    A) Economic and political pressures have widened the therapeutic divide
    B) Reductionistic theory of psychopathology have reinforced separate roles

C) It is not unusual to review case reports in which the therapist and the psychiatrist:
    i. Have little or no direct communication
    ii. May not be using the same diagnoses
D) The psychiatrist may have little or no knowledge of the psychotherapeutic process
E) The psychiatrist may be prescribing meds without any understanding of concomitant psychodynamic or psycho-social issues which are impacting the patient
F) Neither the psychiatrist nor the therapist may be taking into account the issues of transference, either from a classical point of view, or even in regards to how the patient perceives each practitioner vis-à-vis issues such as authority figures regarding issues such as disability, etc.
G) Therapists may not be taking into account how the prescription of psychotropic medications impacts therapy, either on a biological basis or on a psychological basis
    i. Assumption that prescription of psychotropic medications implies a "chemical imbalance" an be a form of resistance to psychotherapeutic exploration
    ii. Need for psychotropic medications may be seen as implying a "failure" of therapy and loss of value of the therapist
H) Psychiatrists may not be taking into account how the process of therapy and other psycho-social issues impact the reaction to medication regarding
    i. Compliance issues
    ii. Issues of trust and related counter-therapeutic or masochistic issues
    iii. Competitive / protective issues
        a) The patient may unconsciously wish to "defeat" the therapist by having medication "resolve" their symptoms;
        b) Conversely, the patient may unconsciously wish to "defeat" the psychiatrist and may use a "failure" of medication to reinforce "blaming" external factors for distress and symptomatology
        c) The patient may feel that a positive response to medications somehow diminishes the status of the therapist
        d) The patient may feel that a positive response to therapy may engender anger or rejection by an perceived authoritarian psychiatrist
    iv. Psychophysiological responses
        a) Any of the above psychological responses may result in unconscious psychophysiological responses to psychotropic medications, particularly the development of side-effects

4) These phenomena not infrequently lead to dysfunctional and/or ineffective treatment protocols, with excessive use of medication, disrupted therapeutic alliances, splitting, poor outcomes, and mutual frustrations

Effective Co-Therapy

1) The split between somatic and psychotherapeutic intervention is largely artificial
    a. Effective psychotherapy must take into account the nature of physiological concomitants of affective pathology
    b. Effective psychopharmacological intervention must include an understanding that patients are not neurotransmitters in Petri dishes, and that an individual's response to medications will be impacted by their perception of the role of prescribing physician and their relationship to the prescribing physician
    c. Effective psychopharmacological intervention requires that medication be carefully monitored and titrated to both symptomatology and external situations and stresses
        i. Increases, decreases or changes in medications may be necessary due to psycho-social circumstances, apart from simply monitoring acute symptomatology (i.e., changes may be made in response to situational factors to proactively *prevent* exacerbations of symptomatology, rather than only *reactively* to changes in symptomatology
2) It is essential that the psychiatrist and the therapist share a common understanding of the patient, and the nature of the pathology present
    a. Differences in case conceptualization can cause confusion in the patient
    b. Therapy can be disrupted by the patient feeling misunderstood by either or both practitioners
    c. The patient may lose trust in either or both practitioners if there clearly is not an integrated plan
    d. Practical issues such as disability status, etc., must be addressed psychotherapeutically consistent with certifications being provided by the M.D. psychiatrist
3) The psychiatrist must be involved in the therapeutic process at least to the extent of understanding the psychotherapeutic and psycho-social issues involved, and the impact of those issues upon the patient's attitude towards, and responses to, psychopharmacological intervention
    a. The psychiatrist himself or herself should feel comfortable in addressing these therapeutic issues with the patient, not simply deferring exploration and confrontation of those issues to the therapist
4) The therapist must be aware of the nature, intended effects, and possible side-effects of prescribed medications, so that physiologically-based symptomatology is not mistaken as psychological symptomatology

5) There must be mutual understanding that transference phenomena is unavoidable
    a. The psychiatrist and therapist must be willing to endure and therapeutically address splitting
    b. If splitting is ignored, it will sabotage treatment
    c. Especially when there one practitioner is male and the other is female, splitting and various projections will be even more significantly engendered
    d. Effectively handled, splitting between therapists can be addressed therapeutically much more effectively than splitting between a therapist and another person in the patient's life
        i. Each practitioner must be careful not to "play into" the splitting, from either the positive side or the negative side
        ii. The practitioners should be comfortable enough with each other to openly discuss splitting that occurs, and acknowledge that there is frequently a "grain of truth" underlying the acting out, i.e., the patient may well "pick up" on realistic positive and negative aspects of the personalities of each practitioner
            1. if the practitioners cannot openly address those issues with each other, their own conflicts will reverberate with the patient, and sabotage the therapy

6) Communication between the psychiatrist and therapist must be frequent and regular, even if the protocol of psychotropic medications is "stable"
    a. It must be recognized that it is the therapist on the "good" side of a split who must make the interpretative intervention in a timely and therapeutic manner.
    b. Having the "positive" therapist suggest that the patient "work it out" with the "negative" therapist will almost always be counter-productive, since the "negative" therapist has already been assigned the role of being negative, and therefore cannot be effective – except possibly in fomenting a reversal of the split
        i. The "positive" therapist, with objective knowledge of the other therapist, can help the patient to objectively evaluate that transference from a less-threatening distance
        ii. It may be useful to schedule additional sessions with the "positive" therapist to work on how the patient can repair the relationship with the "negative" therapist.
            1. if the patient retains respect for the "positive" therapist, and the "positive" therapist can put the patient's concerns about the "negative" therapist into objective perspective, that will constitute both a modeling of repairing relationships and a reinforcement of reality testing; as opposed to the

reinforcement of splitting which more likely occurs in the patient's personal life.

c. With Borderline-spectrum patients, the allowance of formation of splitting between the practitioners and then the therapeutic resolution of those issues can be much more therapeutically effective than attempting to identify and resolve splitting that is occurring in the patient's personal life.
    i. Frequently, with borderline patients, the resolution of splitting – in different directions – will become the focus of the therapy, and often more effective in addressing underlying dynamics than individual therapy or psychopharmacological intervention

7) Even with "neurotic" patients, where unconscious splitting is not a significant factor, issues such as parental roles, reactions to authority figures, stereotypical gender issues may be effectively addressed through a co-therapy model where both practitioners are aware of, and integrate their interventions regarding, all issues that arise.
    a. If the psychiatrist only prescribes and refers all therapeutic issues to the therapist, stereotypes will be reinforced
    b. If the therapist only delves into dynamics and psycho-social issues, and defers exploring affective and/or neurovegetative symptomatology to the psychiatrist, then the ability to explore psychological meaning and significance of those symptoms will be lost

In conclusion, regardless of the specific psychotropic medications prescribed, or the specific issues which are initially brought into the therapeutic sessions, co-therapy *of itself*, can be an effective and rewarding treatment protocol, which takes particular effort on the part of both practitioners, but in the long run can aid the progress of the therapeutic process and reduce frequency and duration of periods of regression.