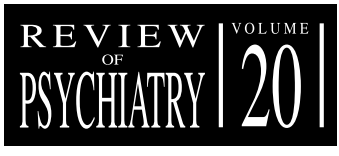
Integrated Treatment of Psychiatric Disorders

Review of Psychiatry Series
John M. Oldham, M.D.
Michelle B. Riba, M.D., M.S.
Series Editors

Integrated Treatment of Psychiatric Disorders

EDITED BY

Jerald Kay, M.D.



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Contents

Contributors **ix**
Introduction to the Review of Psychiatry Series **xi**
John M. Oldham, M.D., and
Michelle B. Riba, M.D., M.S., Series Editors
Foreword **xv**
Jerald Kay, M.D.

Chapter 1
Integrated Treatment: An Overview **1**
Jerald Kay, M.D.
Introduction 1
Integrated Treatment and the Definition of Psychiatry 2
Historical Resistance to Integrated Treatment 4
Potential Beneficial Effects of Integrated Treatment 4
Are Integrated Treatment and Combined Treatment Effective? 8
Substance-Related Disorders 16
Personality Disorders 16
Integrated Treatment: Unanswered Scientific Questions 20
Recommendations for the Clinician 22
References 24

Chapter 2
Psychodynamic Therapy and Medication: Can Treatments in Conflict Be Integrated? **31**
Steven P. Roose, M.D.
Introduction 31
Historical Review 32
Changing Attitudes 36

Is an Integrated Model Possible? 42
Clinical Care: Sequencing Treatments 43
Clinical Recommendations 45
Conclusion 48
References 49

Chapter 3
Integrated Treatment Planning for Borderline Personality Disorder **51**
John M. Oldham, M.D.
Introduction 51
Assessment 52
Developing a Biopsychosocial Treatment Plan 61
Summary and Conclusions 73
References 73

Chapter 4
Integrated Treatment of Alcohol, Tobacco, and Other Drug Addictions **79**
Douglas Ziedonis, M.D., M.P.H.
Jonathan Krejci, Ph.D.
Sylvia Atdjian, M.D.
Introduction 79
Goals of Psychotherapy for Substance Use Disorders 81
Specific Psychotherapies for Substance Use Disorders 85
Timing and Role of Medications for Substance Use Disorders 88
Combined Treatment Studies For Opioid, Alcohol, Cocaine, and Alcohol Use Disorders 91
Recommendations and Conclusions 103
References 104

Chapter 5

A Cognitive Therapy Approach to Medication Compliance **113**

Judith S. Beck, Ph.D.

Introduction 113
The Cognitive Model of Noncompliance 114
Preventing Compliance Problems 121
Uncovering Noncompliance 124
Specifying the Causes of Noncompliance 125
Behavioral Techniques to Increase Compliance 126
Cognitive Techniques to Increase Compliance 127
Examining Advantages and Disadvantages 129
Conducting "Experiments" 133
Eliciting and Responding to Patients' Automatic Thoughts 135
Giving Self-Credit 136
Positive and Negative Imagery 137
Cognitive Restructuring of Core Beliefs 139
Summary 139
References 139

Chapter 6

The Challenges of Split Treatment **143**

Michelle B. Riba, M.D., M.S.
Richard Balon, M.D.

Introduction 144
Positive Aspects of Split Treatment 147
Negative Aspects of Split Treatment 152
Toward Successful Split Treatment 158
References 162

Afterword **165**

Jerald Kay, M.D.

Index **167**

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Sylvia Atdjian, M.D.
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Introduction to the Review of Psychiatry Series

John M. Oldham, M.D., and
Michelle B. Riba, M.D., M.S., Series Editors

2001 REVIEW OF PSYCHIATRY SERIES TITLES

- *PTSD in Children and Adolescents*
  EDITED BY SPENCER ETH, M.D.
- *Integrated Treatment of Psychiatric Disorders*
  EDITED BY JERALD KAY, M.D.
- *Somatoform and Factitious Disorders*
  EDITED BY KATHARINE A. PHILLIPS, M.D.
- *Treatment of Recurrent Depression*
  EDITED BY JOHN F. GREDEN, M.D.
- *Advances in Brain Imaging*
  EDITED BY JOHN M. MORIHISA, M.D.

In today's rapidly changing world, the dissemination of information is one of its rapidly changing elements. Information virtually assaults us, and proclaimed experts abound. Witness, for example, the 2000 presidential election in the United States, during which instant opinions were plentiful about the previously obscure science of voting machines, the electoral college, and the meaning of the words of the highest court in the land. For medicine the situation is the same: the World Wide Web virtually bulges with health advice, treatment recommendations, and strident warnings about the dangers of this approach or that. Authoritative and reliable guides to help the consumer differentiate between sound advice and unsubstantiated opinion are hard to

come by, and our patients and their families may be misled by bad information without even knowing it.

At no time has it been more important, then, for psychiatrists and other clinicians to be well informed, armed with the very latest findings, and well versed in evidence-based medicine. We have designed Volume 20 of the Review of Psychiatry Series with these trends in mind—to be, if you will, a how-to manual: how to accurately identify illnesses, how to understand where they come from and what is going wrong in specific conditions, how to measure the extent of the problem, and how to design the best treatment, especially for the particularly difficult-to-treat disorders.

The central importance of stress as a pathogen in major mental illness throughout the life cycle is increasingly clear. One form of stress is *trauma.* Extreme trauma can lead to illness at any age, but its potential to set the stage badly for life when severe trauma occurs during early childhood is increasingly recognized. In *PTSD in Children and Adolescents,* Spencer Eth and colleagues review the evidence from animal and human studies of the aberrations, both psychological and biological, that can persist throughout adulthood as a result of trauma experienced during childhood. Newer technologies have led to new knowledge of the profound nature of some of these changes, from persistently altered stress hormones to gene expression and altered protein formation. In turn, hypersensitivities result from this early stress-induced biological programming, so that cognitive and emotional symptom patterns emerge rapidly in reaction to specific environmental stimuli.

Nowhere in the field of medicine is technology advancing more rapidly than in brain imaging, generating a level of excitement that surely surpasses the historical moment when the discovery of the X ray first allowed us to noninvasively see into the living human body. The new imaging methods, fortunately, do not involve the risk of radiation exposure, and the capacity of the newest imaging machines to reveal brain structure and function in great detail is remarkable. Yet in many ways these techniques still elude clinical application, since they are expensive and increasingly complex to administer and interpret. John Morihisa has gathered a group of our best experts to discuss the latest developments in *Advances in Brain Imaging*, and the shift toward

greater clinical utility is clear in their descriptions of these methods. Perhaps most intriguing is the promise that through these methods we can identify, before the onset of symptoms, those most at risk of developing psychiatric disorders, as discussed by Daniel Pine regarding childhood disorders and by Harold Sackeim regarding late-life depression.

Certain conditions, such as the somatoform and factitious disorders, can baffle even our most experienced clinicians. As Katharine Phillips points out in her foreword to *Somatoform and Factitious Disorders*, these disorders frequently go unrecognized or are misdiagnosed, and patients with these conditions may be seen more often in the offices of nonpsychiatric physicians than in those of psychiatrists. Although these conditions have been reported throughout the recorded history of medicine, patients with these disorders either are fully convinced that their problems are "physical" instead of "mental" or choose to present their problems that way. In this book, experienced clinicians provide guidelines to help identify the presence of the somatoform and factitious disorders, as well as recommendations about their treatment.

Treatment of all psychiatric disorders is always evolving, based on new findings and clinical experience; at times, the field has become polarized, with advocates of one approach vying with advocates of another (e.g., psychotherapy versus pharmacotherapy). Patients, however, have the right to receive the best treatment available, and most of the time the best treatment includes psychotherapy *and* pharmacotherapy, as detailed in *Integrated Treatment of Psychiatric Disorders*. Jerald Kay and colleagues propose the term *integrated treatment* for this approach, a recommended fundamental of treatment planning. Psychotherapy alone, of course, may be the best treatment for some patients, just as pharmacotherapy may be the mainstay of treatment for others, but in all cases there should be thoughtful consideration of a combination of these approaches.

Finally, despite tremendous progress in the treatment of most psychiatric disorders, there are some conditions that are stubbornly persistent in spite of the best efforts of our experts. John Greden takes up one such area in *Treatment of Recurrent Depres-*

sion, referring to recurrent depression as one of the most disabling disorders of all, so that, in his opinion, "a call to arms" is needed. Experienced clinicians and researchers review optimal treatment approaches for this clinical population. As well, new strategies, such as vagus nerve stimulation and minimally invasive brain stimulation, are reviewed, indicating the need to go beyond our currently available treatments for these seriously ill patients.

All in all, we believe that Volume 20 admirably succeeds in advising us how to do the best job that can be done at this point to diagnose, understand, measure, and treat some of the most challenging conditions that prompt patients to seek psychiatric help.

Foreword

Jerald Kay, M.D.

Integrated or combined treatment is the simultaneous use of psychotherapy and pharmacotherapy in the treatment of patients with mental disorders. This approach is relevant to patients across a continuum of psychiatric disorders, from the most chronic and disabling to those with more circumscribed and less disruptive symptomatology. Integrated treatment is usually provided by a psychiatrist; however, managed behavioral health care, with its emphasis on cost containment, frequently favors a combined treatment model called split or collaborative treatment. Most often *split treatment* refers to an arrangement whereby a psychiatrist is responsible for medication management while psychotherapy is provided by another mental health professional such as a psychologist, social worker, nurse specialist, or counselor. Although there is little scientific support for the efficacy or cost effectiveness of the split-treatment relationship, it is nevertheless commonplace. There are preliminary studies, however, that demonstrate cost savings when the psychiatrist is providing integrated treatment.

Given the ubiquity of integrated treatment, it is odd that the major scientific and clinical questions about this treatment modality have been attended to only recently. This effort is much needed because integrated treatment, more than any other professional psychiatric activity, defines the field of psychiatry and distinguishes it from other mental health disciplines and other medical specialties. In this volume we not only apprise the reader of the most recent research on this subject but discuss the clinical indications, challenges, helpful approaches, and interventions involved in providing this type of treatment.

In Chapter 1, I provide an introduction to integrated treatment and review the benefits of this type of care. I emphasize that all patients attribute some meaning to the medications they are prescribed. Given the significant problems associated with noncompliant behavior, it behooves the clinician to explore this meaning thoroughly in any treatment. Invariably, this exploration also provides useful information about the psychotherapeutic process and an enhanced appreciation of characterological issues. The literature on integrated and collaborative treatment is reviewed, with a particular emphasis on randomized controlled trials demonstrating positive findings, and recommendations are made for the further study of specific clinical questions. Last, the reader is offered some suggestions and guidance about the effective use of combined treatment.

Since the majority of psychiatrists who provide integrated treatment do so from a psychodynamic perspective, Chapter 2, by Steven Roose, addresses the important question of theoretical support for this type of treatment. The combined use of psychodynamic psychotherapy and medication inherits a legacy of theoretical conflict. Appreciating the neurobiological aspects of psychotherapy will move the field away from dualistic thinking and undoubtedly improve patient care. Roose also explores the concept of sequential treatment, a topic that has only recently been addressed in the scientific literature.

In Chapter 3, John Oldham builds upon the material introduced by Roose, with particular attention to one of the most challenging (yet rather common) psychiatric disorders, borderline personality disorder (BPD). His chapter is especially timely given the forthcoming American Psychiatric Association Practice Guideline on the treatment of this disorder, early drafts of which clearly advocate for integrated treatment. Oldham makes the point that BPD is a heterogeneous group of conditions that can be best approached through examination of the patient's most prominent symptoms. This concept appeals greatly to clinicians who have been troubled by a purely phenomenological approach to diagnosis, which has been at times confusingly overinclusive. A step-by-step process for the comprehensive treatment of patients with BPD is presented here that should be helpful to all psychiatrists.

Chapter 4 also addresses integrated and collaborative treatment of specific disorders. Douglas Ziedonis, Jonathan Krejci, and Sylvia Atdjian review the integrated treatment of substance abuse disorders, which has been marked historically by intense controversy between physicians and nonmedical addiction therapists over the appropriate role of medications. The authors review three of the leading psychotherapies currently in use in the treatment of patients with substance abuse disorders: 12-step facilitation, motivational enhancement therapy, and relapse prevention. They discuss 11 important goals of the use of psychotherapy for addiction. Studies of integrated and collaborative treatment in opioid and nicotine dependence as well as in alcohol and cocaine use disorders are reviewed, highlighting the benefits of adopting a comprehensive treatment approach.

In Chapter 5, Judith Beck writes about an issue central in nearly every medical specialty. She points out that more than 50% of patients prescribed medication fail to follow the instructions provided by their physician. She describes a creative and thorough cognitive therapy approach to dealing with medication compliance problems. Her model for addressing the components of nonadherence is valuable to any psychiatrist using pharmacotherapy. Her chapter should be required reading for all psychiatry residents, since she provides such clear techniques for effective intervention with patients ambivalent about medication.

Last, in Chapter 6, Michelle Riba and Richard Balon consider the virtues and challenges of split treatment. They provide highly relevant direction for the psychiatrist who collaborates with nonphysician mental health professionals. Riba and Balon break down the stages of effective split treatment into their elements, and they present detailed clinical advice relevant to the beginning, middle, and end phases of treatment. Moreover, through numerous clinical vignettes they describe practical and effective interventions.

Chapter 1

Integrated Treatment

An Overview

Jerald Kay, M.D.

Introduction

Integrated or *combined* treatment is the simultaneous prescription of psychotherapy and pharmacotherapy in the treatment of a patient's mental illness. Despite the ubiquity of this practice, relatively little research has been conducted on it until recently. The only information regarding the use of integrated treatment in clinical practice has been provided by the American Psychiatric Association Practice Research Network (PRN). The 1997 PRN survey indicated that approximately 55% of patients received both medication and psychotherapy from either a psychiatrist or other mental health professionals (Pincus et al. 1999). Although unpublished as yet, further data analyses from this same study showed that 59.4% of adult patients with mood disorder received integrated treatment (both psychotherapy and pharmacotherapy) from psychiatrists. Combined or split treatment was associated with a number of important factors, including younger age of psychiatrists and the presence of utilization management techniques. Preliminary findings from the most recent PRN survey (Figure 1–1), of 1,500 randomly selected psychiatrists, indicated that of the patients treated by almost 900 psychiatrists, only one-third did not receive some type of psychotherapy (American Psychiatric Institute for Research and Education 2000). However, caution must be exercised in interpreting the PRN data because of an overly inclusive definition of *psychotherapy*.

Other studies have indicated that for many patients the provision of both psychotherapy and psychopharmacology by psychi-

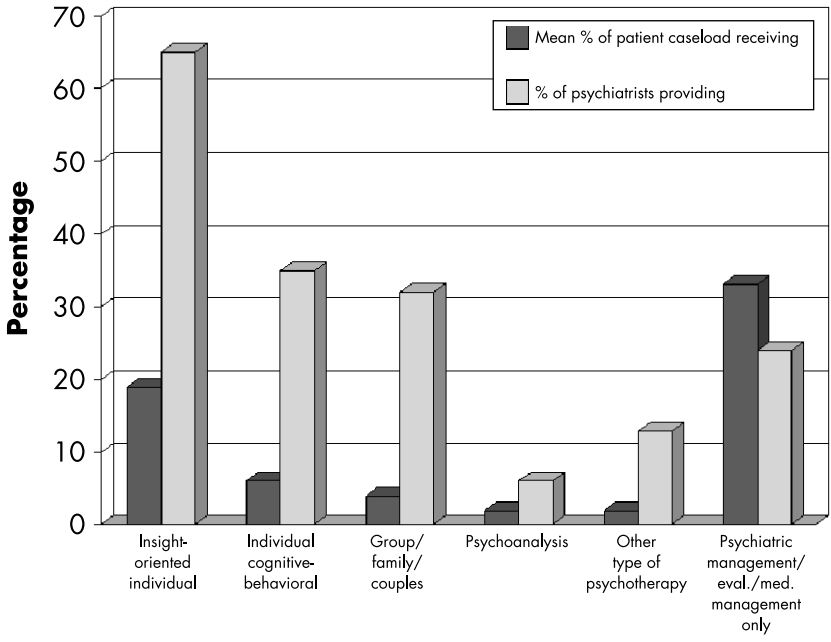

Figure 1–1. Psychotherapy by psychiatrists: findings from the 1998 National Survey of Psychiatric Practice (N = 896).
Source. Reprinted with permission from American Psychiatric Institute for Research and Education: "Are Psychiatrists Commonly Providing Psychotherapy to Their Patients?" *PRN Update,* Spring 2000, p. 2. Copyright 2000, American Psychiatric Institute for Research and Education.

atrists (as opposed to delegation of psychotherapy to other mental health professionals) may be cost saving (Dewan 1999; Goldman 1998). Another study compared treatment of depression by primary care practitioners to treatment by mental health specialists and found that, although the latter was slightly more costly, it resulted in much better patient outcomes (Sturm and Wells 1995). Despite the very small number of studies, the provision of both psychotherapy and medications by the psychiatrist appears to be an important intervention in our therapeutic armamentarium.

Integrated Treatment and the Definition of Psychiatry

Although most psychiatrists advocate a biopsychosocial approach to patient care (Engel 1980), it has never been clear that

this conceptual framework has provided hoped-for direction to the field. Psychiatry remains in practice divided between those who conceptualize treatment from a biological point of view and those who favor a psychosocial view. The mind-body split has not been healed. The practice of combined treatment, recently supported by promising research, thus offers an opportunity to unify our therapeutic approach to our patients and simultaneously reduce distracting tension in our field. Furthermore, psychiatrists' use of both medication and psychotherapy in treatment creates the clearest possible professional distinction between psychiatrists and other physicians and mental health professionals, a distinction critical for the identity and economic future of the field for practitioners and trainees.

Exciting findings from neuroscience have demonstrated the presence of neuronal plasticity within the human central nervous system. The hippocampus, for example, which is vital to learning and memory, produces new cells daily (Eriksson et al. 1998). Psychotherapy itself is a learning process whereby patients acquire new resources to enhance coping skills; the neurobiological study of psychotherapy is thus becoming a reality (Liggan and Kay 1999). Brain function and structure change with effective psychotherapy (Baxter et al. 1992; Schwartz et al. 1996; Thase et al. 1998; Viinamaki et al. 1998).

With this explosion of knowledge about the neurobiological correlates of psychotherapy and with the demonstrated efficacy and effectiveness of psychotherapeutic treatments such as cognitive-behavioral, interpersonal, psychodynamic, and dialectical behavioral therapies, it would not be prudent to jettison psychotherapy as a core clinical skill in psychiatry. Although there is no scientific support, there are financial incentives in managed behavioral health care for split treatment, in which the psychiatrist manages a patient's medication and another mental health professional provides psychotherapy. However, the field should not abandon the provision of psychotherapy by psychiatrists. Rather, psychotherapy should remain a substantial component of psychiatry residency training programs.

Historical Resistance to Integrated Treatment

The introduction of psychotropic medication in the last century was accompanied by resistance in some quarters (Karasu 1982; Klerman 1991). Claims were made that medication irreparably altered the therapeutic relationship and submerged patients' symptoms and their associated distress, thus decreasing their motivation for understanding their problems. With regard to the therapeutic relationship, it was argued that the introduction of medication encouraged a passive, dependent stance on the patient's part as well as magical thinking of the sort often characteristic of nonpsychiatric doctor-patient relationships. Some critics expressed concerns that medication prematurely weakened defenses and increased the likelihood of symptom substitution (Seitz 1953; Weiss 1965). Introducing medication also raised the possibility that patients' self-esteem would be lowered because they would view themselves as being more ill and needing to rely on something external to function. Still other critics worried that the introduction of medication made patients feel they were less interesting to the psychiatrist.

On the other hand, those psychiatrists advocating a purely biological approach to psychiatric disorders were concerned that providing psychotherapy frequently led to symptom exacerbation, which could complicate and prolong treatment. From a reductionistic etiological point of view, psychotherapy is irrelevant to the treatment plan because medication alone is sufficient for improvement.

Potential Beneficial Effects of Integrated Treatment

Opposed to criticisms of integrated treatment are a number of potential beneficial effects, above and beyond the purely medical indications for medication (Klerman 1991). These include the following:

- Medications can reduce some symptoms, which may result in enhancing the patient's self-esteem.

- Pharmacology may permit a patient greater cognitive and verbal access to psychotherapy.
- Medications may improve a patient's autonomous ego functions, such as memory, thought, attention, concentration, and motoric capacities, thereby permitting the ego to marshal greater resources for the psychotherapy.
- Medications may increase the safety within the therapeutic relationship, allowing greater expression of emotion and feeling.
- Pharmacotherapy may promote patient abreaction and allow loosening of defenses, which may make the psychotherapy more effective.
- Pharmacotherapy may be accompanied by a positive placebo effect that reduces the stigma of being treated by a psychiatrist, allowing the formation of a more productive therapeutic alliance.
- The patient's and therapist's feelings about medication and its side effects may provide important insights into the patient's character and emotional state and into the countertransference about the patient, as is often the case with the resistant or noncompliant patient.
- Improvement from medications may illustrate the patient's conflicts about success and accomplishment in the treatment, which are often long-standing and self-defeating.
- During interruptions of psychotherapeutic treatment, medication may provide an enduring connection to the treatment relationship.

Two clinical cases are described below which indicate the value of examining a patient's feelings about medication.

Clinical Case

Mr. A, a 28-year-old accountant, was referred by his pulmonologist for evaluation of depression. He was placed on fluoxetine and began psychoanalytically oriented psychotherapy because of some rather pronounced characterological issues. His depressive symptoms rapidly improved. Six weeks into the treatment, he was asked by the psychiatrist whether there was need for a refill. Mr. A responded that he had run out of medication 6 days earlier because his wife had failed to refill the

prescription. Apparently, it had become her responsibility to monitor his medication. Exploration of this unusual assignment of responsibility by the patient to his wife revealed the fantasy that he had established a test of her caring for him. His wife had disappointed him by failing to observe that he had run out of medication, and he demonstrated this disappointment by discontinuing the medication despite his excellent response to it. Examination of this behavior was remarkably productive in the psychotherapy, delineating the patient's passivity in his marriage, his consistent need for reassurance, and his inability to express his hostility and disappointment about his marriage directly to his wife. He was also able to resume pharmacotherapy.

Clinical Case

Ms. B, 53 years old, was referred to a psychiatrist for psychotherapy and medication. She had recently been discharged from a day-hospital program after experiencing a rather dramatic and disabling major depression. She was an exceptionally accomplished woman whose illness was precipitated by an unusual work-related event: a need arose to terminate a number of workers because of budgetary problems. This act left her conflicted and guilt-ridden. Like Mr. A, this patient had an excellent response to the antidepressant medication but became erratic about taking it. Exploration of this noncompliance revealed that the patient's family was averse to psychotropic medication and saw her need for pharmacotherapy as a weakness of character. Moreover, it became clear that the patient's continuance on medication brought back many memories of her mother, who was incapacitated by bipolar illness. Ms. B resented her mother's unavailability throughout most of her formative years and decided as a teenager that she would never in any fashion identify with her mother. Examination of the adherence issue permitted the patient to reexperience her long-denied resentment of her mother and to develop new approaches to medication with her family members. Subsequently she was able to take her medication as prescribed.

As these cases illustrate, psychotherapy—be it psychodynamic, cognitive-behavioral, or interpersonal—can support pharmacological treatment. Improved adherence to medication and compliance with the treatment approach are significant issues in any therapeutic relationship. In general, psychiatrists agree that

psychotherapy and medications work synergistically. However, the literature has been somewhat inconsistent on this point and varies by diagnosis (Klerman et al. 1994).

The following case demonstrates that medication can be helpful in promoting a more comprehensive treatment experience even in the most complicated of situations and that an effective pharmacotherapeutic alliance is critical to outcome.

Clinical Case

Mr. C was a 28-year-old married father who had undergone liver transplantation. Eight months postoperatively he began to reject his new liver, was hospitalized, and became severely depressed. His depression was marked by crying spells, anhedonia, sleeplessness, suicidal ideation, and pervasive hopelessness. At the transplant surgeon's request, the psychiatrist visited the patient in the hospital and found him to be despondent, tearful, and hopeless. He was difficult to engage, spoke very softly, and avoided nearly all eye contact. His surgeon had informed him that he would undoubtedly require a second transplant, but the patient adamantly refused another operation. Given his difficulty in speaking to the psychiatrist, it was decided (with the patient's consent) first to initiate antidepressant therapy, then to explore the basis of his refusal of further surgery. Within 2 weeks Mr. C's depression began to lift; however, his surgeon was becoming increasingly irritated with him because of his continued refusal to undergo retransplantation.

In an attempt obtain a better understanding of the patient's position, the psychiatrist saw the patient daily. Although the patient denied any fear of dying under surgery, he was able to recall a highly traumatic incident that occurred when he was 16, at which time he nearly drowned while swimming in a rock quarry. When the psychiatrist asked what was the most frightening aspect of the event, the patient described intense panic when he had swallowed large amounts of water and was unable to breathe. When questioned about the possible relationship between this event and his position on retransplantation, Mr. C shared that the most terrifying aspect of the first transplant operation had been his inability to breathe postoperatively because of the numerous tubes in his mouth and nose. Psychoanalytically oriented focal psychotherapy allowed the patient to understand his resistance and to agree to a second operation—providing that his surgeon was aware of and sensitive to his concern.

Are Integrated Treatment and Combined Treatment Effective?

It should be noted that studies of combined treatment for many disorders have not uniformly demonstrated superiority over medication or psychotherapy alone. However, studies across various patient populations have demonstrated the efficacy of combined treatment. A meta-analysis of psychotherapy studies comparing psychodynamic psychotherapy with other therapies, including medication, demonstrated no difference in response; combined treatment, however, was clearly more effective than any monotherapy (Luborsky et al. 1993). In the following sections, the literature on combined treatment for specific disorders is reviewed. The reader should keep in mind, however, that although the discussion focuses on randomized controlled trials, there is much controversy about the usefulness and applicability of this type of study to clinical practice, since study populations often differ in many respects from patients treated in a naturalistic setting.

Mood Disorders

Combined treatment has been studied closely with patients having unipolar depression. A recent randomized controlled study demonstrated that patients with recurrent nonpsychotic major depression were helped most by combining psychotherapy and medication (Reynolds et al. 1999). In this study of nearly 200 elderly patients, the combination of a tricyclic antidepressant and interpersonal psychotherapy (IPT) was more effective in preventing recurrences (for the 107 patients who improved) than either medication or psychotherapy alone. Those treated with nortriptyline and psychotherapy had only a 20% recurrence rate, compared to a 43% rate for those receiving only an antidepressant in a medication clinic setting. The recurrence rate for those treated with IPT and placebo was 64% and was 90% for patients receiving only a placebo.

The largest meta-analysis to date of patients with nonpsychotic unipolar depression (including nearly 600 patients) has demonstrated that for severe depression the combination of medication

and psychotherapy is clearly superior to psychotherapeutic treatments alone, as judged by time to recovery and by outcome (Thase et al. 1997). This meta-analysis examined six standardized treatment protocols from one university. Following these protocols, patients were treated for 16 weeks with either IPT or cognitive-behavioral therapy (CBT). The results were compared with those of studies where patients were treated with both IPT and medication. In patients with less severe depression, psychotherapy was as effective as combined treatment; for severe depression, collaborative treatment was more effective.

Results from the largest randomized controlled study of the treatment of chronic depression with medication, psychotherapy, or both demonstrate conclusively that combination is the most effective option (Keller et al. 2000). This study of 681 patients from multiple locations compared treatment with nefazadone to a cognitive-behavioral psychotherapy called the cognitive-behavioral analysis system of psychotherapy (CBASP). Patients receiving both medication and psychotherapy had an 85% response rate. The response rate of patients receiving nefazadone alone was 55%, and that of patients receiving psychotherapy alone was 52%.

Swiss researchers studied the cost effectiveness of combined treatment for patients referred to outpatient treatment with acute major depression, a group about which there are few studies. Patients receiving both medication and psychodynamic psychotherapy had fewer inpatient days by the end of treatment and at 1-year follow-up (Andreoli et al. 2000). Combined treatment was also associated with lower direct costs and indirect costs (i.e., sick leave).

In an important study of what treatment strategy to use with recurrent unipolar depression, Frank et al. (2000) found that women who did not respond to IPT alone did improve when imipramine was added. Seventy-nine percent of patients responded to this sequential strategy, compared to 66% of patients receiving both psychotherapy and medication from the outset. While this was not a randomized controlled study of a single patient population (patient groups included women treated in an earlier study under similar treatment conditions), it nevertheless raises

a number of issues. First, studies have demonstrated that if patients are treated successfully for an acute episode of their recurrent depression, they are more likely to stay in remission with maintenance treatment (Kupfer et al. 1992; Frank et al. 1993). Second, Frank and colleagues noted that this treatment approach may be particularly appealing to women of child-bearing age who have strong feelings against using medication during pregnancy and lactation.

In an inconclusive study of combined treatment for dysthymia, group CBT by itself was no better than placebo and was less effective in reducing symptoms than was medication alone. However, in conjunction with an antidepressant (sertraline), it was associated with increased functioning for a subset of patients (Ravindran et al. 1999). An investigation of combined treatment for 26 inpatients with double depression indicated that CBT and medication improved short-term, but not long-term, outcome for double depression (Miller et al. 1999).

With respect to the treatment of bipolar disorder, a small nonrandomized controlled study of 10 patients with schizoaffective disorder and 20 with bipolar disorder found that after 3 years, patients receiving systemic family therapy with medication had fewer relapses and hospitalizations than those treated without psychotherapy (Retzer et al. 1991). Moreover, after treatment family members were less likely to view their loved ones as helpless in the face of their illness. In bipolar disorder as in the treatment of schizophrenia, psychotherapy is aimed at adherence to medication and at appreciation for the nature of the illness.

Any balanced discussion must note that the superior efficacy of combined treatment for major depression is by no means proved. In the case of CBT, for example, randomized controlled studies have supported the equivalence of medication alone, psychotherapy alone, and combined treatment (Hollon et al. 1992). In all likelihood, for each study supporting combined treatment there is a study failing to demonstrate any advantage over psychotherapy or medication alone. In particular, three additional meta-analyses assessed the benefits of combining medication and psychotherapy and were unable to demonstrate any advantage over treatment with psychotherapy alone (Antonuc-

cio 1995; Manning et al. 1992; Wexler and Chicchetti 1992). Research design and associated differential attrition are other problems in demonstrating differences in combined studies. Studies have also failed to demonstrate the superiority of combined medication and psychosocial interventions in primary care (Mynor-Wallis et al. 2000). Studies of combined treatment of affective disorders as well as in other diagnostic categories are influenced by ideological differences, professional turf issues, pharmaceutical industry support, and the manner in which mental health services are now delivered under managed care (Eells 1999). Concern has been expressed that nearly all studies of combined treatment have relied on tricyclic antidepressants and that with newer-generation antidepressants there may be greater responses to medication alone in chronically depressed patients (Thase et al. 2000).

Schizophrenia

Despite the severity of this illness, the literature is positive about integrated treatment for schizophrenia. Patients who live with families characterized as having high expressed emotion are at greater risk for relapse after discharge from the hospital. These families tend to be intense, intrusive, and critical of their affected family member. Improved outcome has been demonstrated for patients and their families who receive family therapy that addresses this expressed intensity. This improvement includes illness course and adherence to medication (Falloon et al. 1982; Hogarty et al. 1991; Leff et al. 1985). An 18-month randomized controlled trial of family intervention with medication for first-episode patients showed that only 10% of patients receiving such treatment required readmission to the hospital (Zhang et al. 1994). This was in marked contrast to the readmission rate for patients treated with neither medication nor family therapy—approximately 75%.

Individual psychotherapy has also been shown to be effective in patients with schizophrenia. A 36-month randomized controlled trial found medication with personal psychotherapy to be superior to medication with family and supportive psychotherapies in preventing relapse in those patients who lived with their

families (Hogarty et al. 1997a, 1997b). This type of individual psychotherapy did not rely on interpretation of unconscious conflicts or feelings; rather, the patient's characteristic responses to stress were examined. Additionally, personal therapy provided education about the illness and about effective strategies for dealing with stress and social interaction. Compared to more supportive measures, personal therapy provided persistent improvement in social adjustment for the duration of the study.

Cognitive-behavioral therapy over a 9-month period has been shown to aid patients whose symptoms have not responded completely to medication (Sensky et al. 2000). Medication with rational discussion of delusions and hallucinations was associated with a 50% reduction of symptomatology in this British study of 90 patients. Moreover, these gains persisted after formal therapy was completed, whereas the symptoms of patients receiving medication and a nonspecific befriending relationship did not. Another randomized controlled trial comparing medication with 20 individual CBT sessions to medication alone and medication with supportive care found that 3 months after treatment the first group showed significant improvement in symptom severity, whereas the other two had not made substantial gains (Tarrier et al. 1998).

Another study of individually administered CBT and a social skills training group for 37 treatment-refractory patients started on clozapine found that the 19 patients who received medication with CBT and social skills training showed greater improvement than the control group, who received medication and supportive psychotherapy, which consisted of psychoeducation about their illness, reinforcement of skills, and reassurance (Pinto et al. 1999). Last, a randomized controlled trial of 47 psychotic patients, some receiving CBT and medication and some receiving routine care, found that 18 months after treatment, 65% of the patients receiving combined intervention had reliable improvement as judged by the Brief Psychiatric Rating Scale, compared to 17% of the routine-care group, which received case management and medication (Kuipers et al. 1998). It was also noted that the cost of providing psychotherapy was offset by the decrease in direct and indirect costs associated with the illness.

Despite the severity of this illness, the clinician should remember that patients with schizophrenia and their families tend to value psychotherapy as a very helpful intervention (Coursey et al. 1995; Hatfield et al. 1996) and that the addition of psychotherapy to medication treatments shows great promise for better symptom alleviation.

Anxiety Disorders

Compared to the number of studies using both medication and psychotherapy in the treatment of patients with depression or schizophrenia, the number using this treatment for anxiety disorders is small. Panic disorder has been studied the most; in the treatment of other anxiety disorders, the clinician usually relies on the consensus view as expressed in treatment guidelines. Most psychiatrists use both psychotherapy and medication with many anxiety disorders.

Panic Disorder

There is some evidence that using both medication and psychotherapy in the treatment of panic disorder is more advantageous than using monotherapies. A recent randomized controlled trial with more than 300 participants compared patients with panic disorder who received CBT and imipramine with those who received only medication or only psychotherapy. The combined treatment was superior to either monotherapy as measured at the end of the maintenance stage of treatment (Barlow 2000).

There are few rigorous studies of psychodynamic psychotherapy alone or in combination with medication. This is unfortunate, as the majority of psychiatrists treating patients probably do so from a dynamic point of view. However, the effectiveness of dynamic psychotherapy without medication in the treatment of panic disorder is currently being investigated, and preliminary reports support its usefulness (Milrod et al. 2000). Moreover, a study of brief dynamic psychotherapy with medication concluded that a combination of psychotherapy and clomipramine was more effective than medication alone (Wiborg and Dahl 1996). One group of patients received medication only; a second group received medication and was also

seen for 15 weekly dynamic psychotherapy sessions. Panic symptoms disappeared in all patients in both treatment groups within approximately 6 months. However, after discontinuation of medication at 9 months, the relapse rate for patients who had received both psychotherapy and medication was significantly lower than those who had received only clomipramine. The lower relapse rate was attributed to accomplishments in psychotherapy that allowed patients to function at higher levels.

Earlier studies of the treatment of panic disorder and agoraphobia supported the use of tricyclic antidepressants with behavioral therapy over either monotherapy. Many of these investigations have been summarized by Mavissakalian (1993).

In general, studies have demonstrated that combined treatment with antidepressants is more effective in reducing specific and social phobia as well as functional impairment but appears to be no more effective than psychotherapy or medication alone in reducing the number of panic attacks (Gabbard 2000).

The use of benzodiazepines and behavioral treatment in patients with panic disorder and agoraphobia has also been studied. However, studies have been inconclusive about the advantage of combined treatment with benzodiazepines and behavioral and cognitive-behavioral therapies. Although there is no question about the efficacy of these medications in the treatment of panic disorder with or without agoraphobia (Roth and Fonagy 1996), there has been speculation that benzodiazepines may in some way be responsible for increased relapse rates after the completion of combined treatment as compared with psychotherapy alone (Marks et al. 1993).

Generalized Anxiety Disorder

The literature on combined medication and psychotherapy in the treatment of generalized anxiety disorder (GAD) is very limited. Antidepressants and benzodiazepines are used to treat patients with this disorder. With benzodiazepines, patients with GAD respond rapidly; however, a combined CBT and medication approach achieves a more lasting recovery than medication alone (Power et al. 1990).

Obsessive-Compulsive Disorder

There is general consensus that obsessive-compulsive disorder (OCD) is best treated through an integrated approach using serotonergic antidepressants with exposure and *response prevention*, a type of behavioral therapy (Cottraux et al. 1990; Greist 1995). However there are few controlled studies evaluating the benefits of combined treatment over psychotherapy or medication alone. Behavioral treatment has been repeatedly shown to result in a lower relapse rate than medication. There may also be a role for psychoanalytic psychotherapy in the integrated treatment of OCD when there are psychological conflicts about some symptoms (Kay 1996).

Eating Disorders

A randomized controlled study of 120 women with bulimia nervosa has demonstrated the superiority of antidepressants with CBT in patients with this disorder (Walsh et al. 1997). This study addressed the following questions:

1. Is supportive dynamic psychotherapy superior to CBT?
2. Is a two-step pharmacological intervention employing a tricyclic antidepressant followed by a selective serotonin reuptake inhibitor (SSRI) (if the first medication is poorly tolerated or ineffective) beneficial with psychotherapy?
3. Was combined treatment with either psychotherapy more helpful than medication alone?

The conclusions of this study were as follows:

1. CBT was more effective than supportive dynamic therapy in reducing vomiting and binge eating.
2. Patients treated with medication and either psychological treatment had less depression and binge eating than patients receiving psychological treatment and placebo.
3. CBT with an antidepressant was more effective than CBT alone.
4. Supportive psychotherapy with medication was not superior to medication alone.

5. Two-step antidepressant therapy added modestly to the effectiveness of either psychotherapy.

Substance-Related Disorders

The use of medication with psychotherapy has been shown to be effective in the treatment of opiate-dependent patients (Woody et al. 1995). In one study, 84 methadone maintenance patients were randomly assigned to either 24 weeks of supportive counseling plus supplemental drug counseling or to supportive counseling plus supportive-expressive dynamic psychotherapy. Follow-up after 6 months of treatment demonstrated that those receiving methadone with supportive-expressive therapy had fewer cocaine-positive urine samples and were maintained on lower doses of medication. In an earlier randomized controlled study (McLellan et al. 1993), opiate-dependent patients were assigned to one of three groups. The first group received medication alone, the second medication and counseling, and the third a broad range of services including access to a psychiatrist, an employment counselor, and a family therapist. Those in the last group who received psychotherapy had lower hospitalization rates and better job histories and received less public assistance compared to those in the last group who did not receive psychotherapy. McLellan and colleagues noted the cost effectiveness of adding the additional services. (See Chapter 4 for a comprehensive review of the integrated treatment of addictions.)

Personality Disorders

At present no randomized controlled studies have evaluated medication with psychotherapy against either treatment alone in the treatment of personality disorders. However, a recent randomized controlled study of psychoanalytic psychotherapy versus standard psychiatric care (which did not include psychotherapy) in the treatment of 44 patients with borderline personality disorder demonstrated the effectiveness of psychoanalytic psychotherapy (Bateman and Fonagy 2001). An 18-month follow-

up of these patients, who had received intensive psychotherapy and medication in the context of a partial hospital program of a year and a half, not only maintained their improvement in functioning but demonstrated increased gains in a number of significant areas while receiving ongoing psychoanalytic group psychotherapy twice weekly. These gains included decreased frequency of suicide attempts, self-mutilating behavior, number and duration of inpatient admissions, and use of other psychiatric services. In addition, continued symptomatic improvement in depression, anxiety, and general symptom distress were evident, as well as gains in social adjustment and interpersonal functioning.

General consensus—as represented by the most recent draft of the American Psychiatric Association Practice Guideline for Borderline Personality Disorder (American Psychiatric Association, in press)—supports a role for combined treatment in addressing a host of symptoms in many patients with personality disorders. In borderline personality disorder, for example, medications have been associated with a reduced treatment dropout rate and fewer psychotic regressions and feelings of aloneness, an important concern for many of these patients (Koenigsberg 1994). The use of medications in this group of patients is complex, given its frequent problems with compliance and adherence. Other symptoms commonly treated with combined medication and psychotherapy include affective instability, behavioral dyscontrol, hostility or aggression, and interpersonal sensitivity, to name just a few. Nearly every class of psychotropic medication has been found in noncontrolled studies and clinical reports to be effective; see Table 1-1.

Clinical Case

Mr. D, a 32-year-old lawyer, sought treatment for his longstanding depression. Although he clearly met criteria for a major depression, chief among his concerns was his inability to commit to a relationship with a woman. Despite being exceptionally handsome he experienced himself as repugnant and ugly; each relationship he entered he terminated, for unclear reasons. His work was uniformly admired in his law firm, yet he still felt incompetent and a fraud. Of importance in his fam-

Table 1–1. Medication efficacy in areas of dyscontrol

Medication	Efficacy[a]			
	Cognitions	Affect	Self-destructiveness/ impulsivity	Anxiety
Neuroleptics	+	+	++	+
Tricyclic antidepressants	+/–	+	+/–	+/–
Monoamine oxidase inhibitors	?	+	++	+ (somatic)
Serotonin reuptake inhibitors	++	++	++	+
Carbamazepine	+	+/–	++	?
Benzodiazepines	?	+/–	–	+ (psychic)
Valproate	?	+/–	++	?

Note. The information in this table should be considered tentative, because most of the medication trials in patients with borderline personality disorder have been small and open, and few of the medications listed have been directly compared with one another.
[a]++ = Clear improvement; + = modest improvement; +/- = variable improvement or worsening; - = some worsening.
Source. Reprinted with permission from Gunderson JG, Links PS: "Borderline Personality Disorder," in *Treatments of Psychiatric Disorders*, 3rd Edition. Edited by Gabbard GO. Washington, DC, American Psychiatric Publishing, 2001. Table originally adapted from Phillips KA, Gunderson JG: "Personality Disorders," in *The American Psychiatric Press Textbook of Psychiatry*, 2nd Edition. Edited by Hales RE, Yudofsky SC, Talbott JA. Washington, DC, American Psychiatric Press, 1994, pp 701–728.

ily history was his relationship with his father, whom he idealized but who was also the object of his intense anger. The patient described his father as having superior intellect, outstanding career accomplishments, and strong opinions about every conceivable subject. This man was admired by all and gave freely of himself to his colleagues and to many organizations. However, Mr. D had many unsettling memories of times when he wished his father was as devoted to him as to his employees. The patient recalled having many arguments with his father as a teenager and noted that his father had won them all.

At the conclusion of the first diagnostic interview, the psychiatrist shared his preliminary assessment with the patient and recommended initiation of an antidepressant because of Mr. D's considerable psychological discomfort. Mr. D thanked the psychiatrist politely for this suggestion but stated that medication was not an option for him. The patient felt that to take an antidepressant would destroy him. The psychiatrist was puzzled but listened to the patient for more than 10 minutes. He was empathic with the patient's quandary and explored it but explained that the matter could be revisited at some time in the future.

The patient felt immediate intense relief and became tearful. He had been worried that his refusal of medication would anger the physician and that he would be told to either comply or forgo treatment. Only some weeks later did it become clear that to have followed the psychiatrist's recommendation of medication would have felt, to Mr. D, too much as if the psychiatrist were in a position like that of Mr. D's father. More specifically, it became clear that the patient feared that the psychiatrist would maintain that there was only one way to proceed in treatment, recalling Mr. D's father's absolute conviction of being right on every matter. Once this issue was clarified, the patient agreed to the medication. Understanding his initial refusal had deepened the psychotherapy significantly.

This case illustrates a number of central issues about how patients may attribute meanings to the prescribing of medication and about medication's usefulness in the treatment relationship. As noted earlier, prescribing medications may provide a window into the patient's beliefs, fantasies, fears, and his or her responses

to the doctor-patient relationship at any given moment in the treatment.

Mr. D's response to the offer of medication was dramatic and intense and provided the psychiatrist with an early and invaluable shared experience. First, the patient's response demonstrated that transference is a ubiquitous phenomenon and is not limited to psychodynamically oriented treatments. Second, the specificity of the patient's reaction to medication permitted a clear glimpse of an important earlier conflict with his father that undoubtedly had relevance to the patient's current world and day-to-day relationships. Third, this case has much to teach about the potential countertransferential responses of the physician. While it did not occur in this situation, the physician could have become irritated or angry with the patient for refusing his advice; this could have impacted negatively on the treatment alliance if the both parties had become locked in a struggle over authority. Fourth, the patient's refusal to accept medication foreshadowed the patient's mixed feelings about getting better. That is, it became clear in the treatment that the patient did not feel he *deserved* to improve, much as he felt undeserving in his relationships with women and in his law firm. Fifth, it became obvious later in the treatment that Mr. D's refusal of medication illustrated intense feelings of anger about his competitive relationship with his father. It ultimately became clear that the patient was frightened of outperforming his father because he was convinced that if this should indeed happen his father would want nothing more to do with him and would end the father-son relationship in anger.

Medications may have many other meanings to patients; some of these are highlighted in Table 1-2.

Integrated Treatment: Unanswered Scientific Questions

Despite the rigorous scientific studies of the last decade on collaborative treatment, a number of issues central to the use of integrated treatment must still be addressed. These issues include but are not limited to the following:

Table 1–2. Patients' feelings about the psychiatrist and about medication

Feelings about the psychiatrist	
Positive	**Negative**
Genuine acknowledgment of pain	Discomfort with patient's plight
Interest in patient's feelings	Lack of interest in patient's feelings
Support and safety	Physician's control of patient
Hopefulness about symptom relief	Minimization of patient's problems
Appreciation of clinician's skills	Fear of limited skills of clinician
Comfort with consistency of prescribing	Anger over clinician's refusal to prescribe what patient desires or feels is needed

Feelings about medication	
Positive	**Negative**
Relief that correct intervention is offered	Evidence of patient's weakness
Reassurance about gradual onset of action	Fear that psychiatrist is inept or uncaring
Trustworthy and effective intervention	Fear of toxic or hurtful suggestion
Appreciation of integrative treatment plan	Resentment that effective component of treatment is unclear

- Under what conditions is integrated treatment by a psychiatrist superior to split treatment?
- For what disorders should psychotherapy precede medication?
- For what disorders should both medication and psychotherapy be instituted from the outset of treatment?
- Are some psychiatrists more effective in using integrated treatment? If so, why?
- For which disorders is integrated treatment cost effective?
- What factors are critical in the success of split treatment?
- What are the benefits of brief integrated therapies of 12–16 sessions compared with longer treatments for some disorders?

Recommendations for the Clinician

There are a number of principles that will assist the psychiatrist in using integrated treatment.

1. The clinician should not assume that making the correct diagnosis and providing the most scientifically supported medication guarantees the establishment of a solid therapeutic alliance. No treatment will succeed without a safe, noncritical, and empathic working relationship between doctor and patient. Medication adherence problems are ubiquitous, prevent the relief of much discomfort in patients, their families, and important relationships, and add greatly to direct and indirect health care costs.
2. The psychiatrist should adopt a system to routinely and specifically address medications in combined treatment. For example, the clinician may discuss medication issues at the beginning or at the end of a session. There are virtues to each method. With the former, the entire session may provide important material about the therapeutic relationship. However, some clinicians are concerned that opening the session with questions about medication will influence the content and process of the entire visit. Others argue that by leaving the medication inquiry to the end, important dialogue may be closed prematurely. Still others hold that it is best to address medication issues whenever they arise in the session's material (if they do arise). Regardless of the chosen approach, it is crucial to establish a routine that will provide consistency and predictability to meetings. Deviations from this process will alert the clinician to the possibility of countertransference phenomena. Asking specific questions about the likelihood of a patient's taking medication, permitting sufficient time to explore fears and fantasies about this component of the treatment, and providing comprehensive information about indications, side effects, and advantages of taking medication are vital in the provision of effective integrated treatment.
3. Attention must be paid to patient's questions about side effects, to changes in medication type and dosage, and to the discontinuation of medication, all of which often provide additional

psychotherapeutic material. For example, excessive complaints about side effects suggest the possibility of resistance to the psychotherapy. Or, prescribing medication for the first time in ongoing expressive psychotherapy may signal the psychiatrist's growing frustration with a stalled psychotherapy.

4. Termination of successful treatment often brings a return of the patient's symptoms. The clinician should not assume in such cases that providing additional medication is the most helpful intervention. Exacerbation of symptoms can frequently be understood as a patient's response to ending an important, caring, and productive relationship. Similarly, a patient's request for more medication in the termination phase of psychotherapy requires an exploration of ambivalence about closure of therapy and may indicate a wish to prolong the doctor-patient relationship.
5. A clinician must learn to perform two clinical tasks seamlessly in the prescribing of medication within the context of psychotherapy. In addition to listening reflectively to the patient's communication, the clinician must be directive in eliciting medication effects and side effects and often may request that the patient complete rating scales. The clinician must as well provide information for the patient about pharmacodynamics and discuss supporting scientific literature for the recommended drug intervention.
6. Although it remains to be established, there may be a number of disorders and clinical situations in which integrated treatment should be considered rather than collaborative interventions. For example, as in the case of Mr. C, patients with complex medical problems often do better with a psychiatrist providing psychotherapy and medication. The psychiatrist better appreciates the interplay between the biological and psychosocial factors in many serious medical illnesses, not to mention drug-drug interactions, by virtue of his or training as a physician. For many patients with borderline or narcissistic personality disorders, who polarize their helping relationships, have a significant propensity for self-harm, and have required frequent hospitalizations, the psychiatrist can provide a higher level of continuity of care throughout the

treatment process, especially when an emergency or the need for hospitalization arises. Many practitioners treating noncompliant patients who have Axis I disorders such as schizophrenia and bipolar disorder also prefer an integrative treatment approach, since it can provide a more comprehensive level of care through the monitoring of symptoms while also making possible the discussion of challenging psychoeducational issues. It should be noted that these examples are by no means exhaustive and that many psychiatrists believe that integrative treatment is nearly always the treatment of choice. Research therefore is desperately needed in order to support this practice, to identify the profession more distinctly, and to address arbitrary financial restrictions on access to care for our patients and their families.

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Chapter 2

Psychodynamic Therapy and Medication

Can Treatments in Conflict Be Integrated?

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Introduction

In clinical practice many forms of psychotherapy are given in combination with psychotropic medication, so it is not at all striking that this book should include a chapter on the integration of psychodynamic therapies and medication. However, what is commonplace today was not always so, and it should be noted that combining psychodynamic treatments with medication represents a major paradigm shift within the past generation. When psychotropic medications were first introduced into clinical psychiatry the influence of psychoanalytic metapsychology and technique was at its apex—and never were two treatments more theoretically and technically incompatible.

In this chapter I focus on the psychodynamic viewpoint rather than specifically on psychoanalysis or psychoanalytic psychotherapy; historically, most of discussion and literature on this issue has come from the psychoanalytic community. The chapter 1) reviews the early adversarial reaction of psychodynamic therapists to the development of effective psychotropic medication and illustrates this reaction with a clinical example, 2) traces the transformation of this adversarial relationship into the clinical practice of combining medication and dynamic therapies, 3) explicates the theoretical problems that exist in our current conceptualization of combining medication and dynamic therapies, 4) discusses a developing theoretical model that avoids the

traditional mind-body splits and illustrates the model with a case example, and 5) offers guidelines for clinical practice.

Historical Review

It is worthwhile to review the relatively brief history of the relationship between medication and psychodynamic therapy, as some current problems in integrating these two treatments still reflect the original conflict. When psychotropic medication first became available for the treatment of psychiatric disorders, the new treatment modality was met with skepticism or (more frequently) outright rejection by the psychodynamic community (Sarwer-Foner 1960). The analytic literature on this topic reflected a treatment hierarchy in which psychological treatment—specifically, analytic treatment—was considered deep, curative, and to be left undisturbed whenever possible. Medication was thought to relieve symptoms without affecting the underlying psychic conflicts that were considered the etiology of psychological illness. The use of psychotropic medication to reduce symptom intensity was therefore seen as poor medical practice, equivalent to giving a patient with an acute abdomen an analgesic: in the short term it might relieve discomfort, but in the long term it could do significant harm by masking symptoms necessary for accurate diagnosis and so preventing the initiation of definitive (rather than palliative) treatment. Medications were seen as quick and superficial, to be used primarily by therapists who would not or could not engage in the complex and demanding long-term relationship with the patient necessary to achieve sustained structural change.

In order to understand rather than trivialize this attitude, the psychoanalyst's position needs to be considered in the context of the psychodynamic theory of symptoms and etiology of neurosis and psychosis. Traditional psychodynamic theory considers symptoms the products of psychic conflict: symptoms, whether behaviors such as hand washing or affect states such as depression or anxiety, serve to defend against while yet allowing for controlled discharge of intolerable feelings that could potentially overwhelm the ego. Treatment directed at symptoms may reduce

the fever, as it were, but will not cure the infection; medications do not address the underlying psychic conflict. Moreover, the experience of painful affect states such as depression or anxiety was seen as a critical part of the patient's motivation for treatment. The use of medication to reduce anxiety or depression would be contrary to the patient's best interests because it would reduce the patient's motivation to commit to the lengthy psychodynamic treatment that ultimately produces enduring change. Furthermore, the prescription of medication by the therapist was seen as incompatible with the principal of maintaining technical neutrality, one tenet of which is to avoid gratifying the patient. To quickly relieve a symptom would be to gratify an infantile wish of the patient and would thus represent an enactment, not an interpretation.

However theoretically opposed psychodynamic clinicians may have been to the implications of medication use, their pragmatic side always allowed for exceptions. It was appreciated that a reduction in florid symptoms, albeit superficial, could be useful insofar as it controlled behavior disruptive to the development of transference, thereby facilitating the dynamic treatment which was the true therapeutic process. Indeed, no less a personage than Anna Freud commented during a visit to the psychoanalytic community in the United States that she was

> surprised at the almost complete rejection of drugs during psychoanalytic treatment . . . as far as I am concerned I have had great help from medical colleagues used to the administering of modern drugs with three patients in severe states of depression. In all of these cases, the therapeutic use of drugs did not in any way interfere with the progress of the analysis, quite on the contrary, it helped the analysis to maintain itself during phases when otherwise the patient might have had to be hospitalized. (Lipton 1983, p. 1583)

Thus the pragmatic side of some psychoanalysts quietly allowed for the use of medication as an adjunctive treatment to dynamic therapy—though they might still have proclaimed that even when medication was necessary to treat severe symptoms that interfered with the analytic process, it was an undesirable intrusion that should be a last resort and was, even when effective, a necessary evil.

A case I was asked to see in consultation illustrates 1) the theoretical conflict between a psychodynamic theory of symptoms and a clinical, phenomenological diagnostic system (e.g., that of DSM-IV; American Psychiatric Association 1994) and 2) how this conflict influenced the patient's treatment.

Clinical Case

Ms. E, a 32-year-old married woman, called asking for a consultation about the possible use of medication to treat her chronic depressive symptoms. Though she had been in psychoanalysis for 3 years, she was self-referred for this consultation. The consultation was prompted by the positive response of a friend to antidepressant medication. This friend had recently been treated by a colleague of mine, and that colleague had given the patient my name. As is my procedure, I told the patient that I would be happy to see her in consultation but would like her permission to speak to her analyst ahead of time; she agreed.

Although Ms. E's analyst believed that her wish for a consultation represented an acting out of transference, the analyst did not want to interdict the patient's behavior and was open to discussing the case with me. The patient had had a hostile relationship with her mother, who was characterized as a depressed and phobic woman who much preferred the patient's older brother. The patient's mother died suddenly of a cerebral hemorrhage when the patient was 17. At that time the relationship between the patient and her mother was marked by periods of open battle alternating with extended intervals of silent coldness. The analyst's dynamic formulation explained the patient's depressive symptomatology as a consequence of pathologic mourning for the mother and of the chronic experience of unfulfilled yearning for a fantasized loving teacher/mother, a yearning which predated the mother's death. The patient's depressive symptomatology also served an important defensive function: to ward off the anxiety that she would experience if she were conscious of her fantasy that her rage had annihilated her mother and would eventually consume her as well. Furthermore, the patient experienced any form of success (i.e., pleasure) as a victory over her mother, which would induce an intolerable level of oedipally derived guilt. Thus, the analyst considered the patient's chronic depressive feelings to be a part of her character armor, which must be systematically interpreted to allow access to the unconscious fantasy at the core of the patient's psychic conflict. The analyst judged that the patient

was in the midphase of the analysis and that there was a good therapeutic alliance and a deepening analytic process. The desire of the patient for medication to treat her depressive symptoms was, in his view, a reaction to the deepening of the analytic process and her developing relationship with the analyst—an attempt to reinforce her defensive structure against weakening by interpretation.

I saw Ms. E in consultation and found that she met DSM-III-R criteria for dysthymic disorder. I discussed openly with her the conflict between the psychodynamic and phenomenological systems of diagnosis and emphasized that the diagnosis of dysthymic disorder was based on phenomenology, not etiology. I reviewed with her the evidence that antidepressant medication had been demonstrated to be helpful in a significant number of patients with her condition, and, of course, that the nature of the treatment said nothing about the etiology of the illness, i.e., taking a medication does not mean that there is a "biological illness" any more than psychotherapy means that there is a "psychological illness." She reflected that she had come to believe that depressive feelings created events in her life as much as reflected them, particularly in interpersonal relationships. For example, she realized that she had often misinterpreted her depression as indicating that she did not really love her boyfriend. She was frustrated in analysis because despite what she acknowledged was a deepening understanding of herself, the depressive symptoms were unrelenting. She was eager to try antidepressant medication—indeed, wanted a prescription before she left the office. I explained that there was a process to be followed in a successful consultation and the next step was for both her and me to discuss the results of this consultation with her analyst.

My viewpoint, which I shared with Ms. E's analyst, was that as a psychoanalyst myself, I considered it to be a given that at least some part of the patient's motivation for seeking a consultation *at this time* was grounded in negative transference and that therefore the consultation was an acting out. Nor did I have any reason to disagree with the analyst's well-constructed formulation. However, though a dynamic formulation can be helpful in understanding the meaning and function of the depressive symptoms in the patient's life, it does not explain the etiology of a depressive disorder. Furthermore, though the consultation may

be an acting out, the appropriateness of medication is not evaluated based on this kind of data. The analyst acknowledged that there were other ways of understanding depressive disorders; indeed, she had recommended medication at times for other patients. However, she strongly believed that in this case the medication would interfere with the analytic treatment. The analyst was not frustrated with the pace of the analytic process and felt that this was simply the mid-phase of what was going to be a somewhat long and difficult analysis.

The analyst and I agreed to disagree about the medication. Not surprisingly, the patient called me back and said that she had decided not to take medication at this time but would continue to try to "work through" her depressive symptoms. My point is not that I was right and the analyst wrong about the appropriateness of medication treatment in this case (although I do believe that I was right and she was wrong), but that the psychodynamic clinician's decision against medication was based on her understanding of the *meaning* of depression in the patient's dynamic structure; she believed that reduction of the depressive symptoms would be counterproductive in the analytic situation.

Changing Attitudes

The psychodynamic community's initially unfavorable view of psychotropic medication was subsequently muted by substantive and reproducible data from double-blind, placebo-controlled studies establishing the beneficial effect of medication in the treatment of schizophrenia and affective disorders. A second generation of studies (particularly in the field of affective disorders) indicated that though medication alone had a robust effect, combined treatment was often superior to medication alone, especially by measures of social functioning (Weissman et al. 1979). One study (Rounsaville et al. 1981), a secondary analysis of data from a collaborative study of depression, was particularly important because it directly addressed the psychodynamic community's beliefs about the negative impact of medication on psychotherapy. Rounsaville and colleagues summarized their findings as follows:

> [T]he researchers tested the hierarchical view that therapy is superior to drugs and that drugs interfere with therapy. They distilled four traditional hypotheses of negative interactions: 1) Drugs could be a negative placebo, increasing dependency and prolonging some kinds of psychopathology. 2) Drug relief of symptoms could reduce motivation for further therapy. 3) Drugs could eliminate one symptom and create others by symptom substitution if underlying conflicts remain intact. 4) Drugs could decrease self-esteem by leading the patient to believe that he/she were not interesting enough for insight oriented work. They also examined the reverse position, that psychotherapy could be harmful in patients sick enough to need medication, either by promoting regression or by encouraging the patient inappropriately not to use drugs. Careful statistical evaluation of outcomes in large samples receiving different treatment combinations revealed no negative interactions. On the contrary, their work supported the theory that two treatments are additive not conflicting. (Rounsaville et al. 1981, p. 29)

The psychodynamic community began to reconsider the possible beneficial effects of combined medication and psychotherapy. Cooper (1985) reviewed the treatment of a patient with a masochistic personality and dysthymic disorder and concluded that "retrospectively pharmacological assistance earlier might have provided a much clearer focus on her content-related psychodynamic problems and would have made it more difficult for her to use her symptoms masochistically as proof that she was an innocent victim of endless emotional pain" (p. 1399). Esman (1989), in an attempt to integrate recent research findings on obsessive-compulsive disorder with psychodynamic concepts, concluded that "recent findings raise serious questions about the conflictual origins of the obsessional character" and that "one-dimensional models of such disorders can no longer be maintained" (p. 329). Such a conclusion clearly implies that combining multiple modalities in treatment is consistent with a more sophisticated concept of this illness.

Perhaps more important than the moderating tone of the psychodynamic literature were changes in clinical practice, where it was quite evident that combining antidepressant and antianxiety medications with psychodynamic psychotherapy was increasingly common. In fact, two studies done at the Center for Psychoan-

alytic Training and Research, Columbia University, documented the prevalence of combined treatment. In 1996 a survey of training analysts (Donovan and Roose 1995) discovered that 20% of these analysts' patients within the past 5 years had been prescribed psychotropic medications. This was not a practice restricted to a few analysts in training; 60% reported that they had at least one patient receiving medication. In the second study (Stern 1995) it was reported that 30% of psychoanalytic candidates' training cases were being prescribed medication. In both studies, 90% of patients taking medication had been diagnosed with an affective disorder (either dysthymia or major depressive disorder) and the medication prescribed was an antidepressant—most frequently a selective serotonin reuptake inhibitor. In both surveys analysts were asked to rate the antidepressant effect of the medication and the impact of medication on the analytic process. Invariably the analyst rated the medication as very effective and stated that concurrent with the antidepressant effect was a deepening of the analytic process.

Although antidepressant medications are being prescribed more frequently, they may still be underutilized by psychodynamic clinicians. In a subsequent study at the same psychoanalytic center (Vaughn et al. 2000), patients entering analysis were given structured interviews to ascertain DSM-IV diagnoses. Over 50% of patients met diagnostic criteria for either current major depressive disorder or dysthymia. This study also found a strong correlation between high depression scores on the Beck Depression Inventory and low scores on an assessment of insight, the Psychological Mindedness Scale. It appears that insight and other cognitive processes necessary for engagement in psychodynamic treatment diminish as depression increases. At 1-year follow-up, patients whose depressive symptoms had resolved also had significantly higher scores on the Psychological Mindedness Scale than before and, not surprisingly, were deeply involved in their psychodynamic therapy. Intriguingly, patients with current depressive disorder undergoing analysis without antidepressant medication had a significantly higher dropout rate in the first 6 months (50%) than depressed patients taking antidepressant medications (0%).

Thus, psychodynamic physicians do indeed prescribe medication for their patients and believe that these medications can be robustly effective and have a beneficial impact on the therapeutic process. Whatever psychoanalysts' original reasons for opposing medication, theoretical or technical, those reasons' power has attenuated in the face of the substantial therapeutic benefit of medication used in selected cases. But psychodynamic clinicians tend to be theory-down in their approach, and it is necessary to have some theoretical resolution to old conflicts in parallel with pragmatic clinical practice. I once thought that a possible solution was for analysts to put aside their desire to determine the etiology of depression, but now believe that it is not necessary to abandon a psychodynamic model of the mind in order for the therapist to develop a clinical stance that allows for use of medication. Phenomenology is the relevant approach when deciding upon medication treatment, because the studies that established the efficacy of medication in anxiety or depressive disorders included patients based on the phenomenology of their symptoms—their chronicity, form, and intensity—but not the presumed etiology or meaning of those symptoms. The patients included in such pharmacological studies undoubtedly had elaborate conscious and unconscious fantasies to explain their symptoms. Although critically important for one form of treatment (i.e., psychodynamic psychotherapy), meaning and fantasy are not the data necessary to diagnosis of a depressive or anxiety disorder and to the recommending of medication. If a patient meets diagnostic criteria for such a disorder then all treatments proven effective in that disorder should be considered. In fact, psychodynamic clinicians have already come to this position with respect to the treatment of schizophrenia or melancholic depressions (Kantor 1990). Though some psychodynamic clinicians might still maintain that they can determine both the cause and meaning of a hallucination or depressive symptom, they would probably concur that rapidly effective pharmacological therapies are the initial treatments of choice.

My intent of separating phenomenology from dynamic meaning was twofold: 1) to ensure that in psychodynamic treatment settings, medication decisions would be based on the same type

of data that was used in the studies that established medication efficacy, and 2) to reduce theoretical conflict, thereby allowing an already burgeoning clinical practice to flourish. Indeed, I believe that this solution did reduce adversarial tones in the short run and help bring about a truce, if not a peace. However, this solution does not represent true theoretical integration and has inadvertently supported the mind-body dichotomy that has plagued our field. For example, some clinicians now divide psychopathology into Axis I and Axis II disorders. These are thought to represent brain and mind disorders respectively, thereby perpetuating a dualistic split. Axis I disorders are biological, or "hardwired," that is, not derived from psychic conflict, and therefore are not amenable to psychotherapeutic interventions and require somatic treatments exclusively. In contrast, Axis II disorders result from psychic conflict and therefore are amenable to interpretation. For these disorders, psychological treatments and not medication are the primary modality of treatment. Such a division allows psychodynamic clinicians to preserve their domain by separating character structure from affective disorder; the psychodynamic treatment can then proceed uncontaminated by the medication treatment, which affects another dimension of the patient. Thus, although acceptance of a phenomenological perspective by psychodynamic clinicians probably advanced the use of medication in combination with therapy, it significantly deepened the mind-body conflict.

If mind-body dualism is unresolved for the therapist, it will certainly be manifest in the patient's experience of taking medication. This can be illustrated by explicating the meaning of questions that patients commonly ask: "You are giving me a medication. Does this mean I have a biological illness?" This question implies that the alternative to a biological illness is a psychological illness; if the clinician distinguishes Axis I from Axis II disorders in these terms, then they will probably tell the patient that the medication is treating their Axis I biological illness and the psychotherapy is going to treat their Axis II psychological illness. Yet the patient's question may not be exclusively or even primarily about the mind-body dichotomy. The patient is stating a fantasy that, if their illness is biological, then they cannot control it, in

which case they are not responsible, it is not their fault. The rationale would run, "My problems, my illness, are not a reflection of my weakness but rather of bad luck or bad genes." A psychopharmacologist, as much as a psychotherapist, needs to understand the patient's fantasies to be therapeutically effective.

A second question that is often expressed when a patient is struggling with the decision to take medication is: "I do not want to go through life in an altered state. I mean, is this really me?" The patient's fear is that an effective medication is creating an altered state, a false self. It is not that the patient necessarily experiences the "false" self as unpleasant; on the contrary, it is common for patients on medication, particularly when medication treats chronic anxiety or depressive states, to report a decrease in inhibition in their social, vocational, and intellectual life. As one patient expressed it, "I can't believe what I am doing, at work or with women. I would never have done these things before, even though I might have wanted to." In fact, the experience of pleasure after effective medication treatment can create a new anxiety; the patient feels that if these changes are not under their control then they can be taken away at any time. As one patient said, "Twelve o'clock will come and I will turn back into a pumpkin." Such a belief has its roots in negative transference and the patient's experience of the therapist as an either intentionally sadistic or inadvertently hurtful parent.

Ironically, many of the patients (and indeed, many of the therapists) who struggle most with the issue of medication have become acclimated to mood-altering pharmacological or behavioral interventions. Nicotine, alcohol, caffeine, and vigorous exercise are the antianxiety and antidepressant medications of everyday life.

Another manifestation of the mind-body conflict is that a psychodynamic clinician will rarely conceptualize a treatment sequence in which medication alone is the primary modality, with the dynamic treatment to be added only if necessary. Psychotherapists still consider medication to be adjunctive treatment, to be added to the primary treatment (i.e., the dynamic therapy) only if the patient's symptoms are refractory to interpretation. This is especially so if medication is used to treat syndromes traditional-

ly associated with character pathology, such as eating disorders, some mild chronic depressive disorders, generalized anxiety disorder, and (perhaps most notably) borderline personality disorder (see Chapter 3). However, there are no data to support the relegation of medication to adjunctive status.

Is an Integrated Model Possible?

If we are truly to integrate medication and dynamic theories and not simply give them in combination, we need to abandon the Axis I–Axis II dichotomy and develop a model in which medication and psychodynamic treatment are complementary, not hierarchical, and can be considered different treatments directed toward different aspects of the same illness. An elegant theoretical model along these lines is presented by Gorman et al. (2000). This comprehensive review of the literature on the phenomenology, neurobiology, and treatment of panic disorder proposes a neuroanatomy and neurophysiology of anxiety symptoms such as panic attacks, anticipatory anxiety, and phobic elaborations. The model proposed is based on the neuroanatomical pathways of the viscerosensory information processing centers in the brain. Gorman and colleagues conclude:

> [T]here are many neuroanatomical sites that likely subserve the cognitive and relationship difficulties that ultimately may be the worst part of panic disorder. We have suggested that cortical sites, particularly those that process higher order sensory information such as the medial prefrontal cortex, are important in modulating anxiety responses. As LeDoux has suggested, "psychotherapy may work, in part, by strengthening the ability of these cortical projections to assert reason over automatic behavioral and physical responses." Medications, in our opinion, are only partially helpful in reversing the incessantly gloomy predictions of patients with panic disorder or in helping them rearrange relationships that are based on safety and dependency. Depending on the severity of these problems, which often correlates with how long a patient has had panic disorder, psychotherapy becomes invaluable. (Gorman et al. 2000, p. 502)

This conclusion represents true integration of dynamic therapy and medication because it implicitly recognizes that effective

psychotherapy must at some point affect neurostructures, as proposed by Kandel more than 20 years ago (Kandel 1979), thus that effective treatments are neither psychological *nor* biological: the origins of these disorders are both psychological *and* biological.

Clinical Care: Sequencing Treatments

In an integrated approach, treatments are likely to be sequenced rather than given in combination, thereby adhering to one of the basic tenets of therapeutics: if possible, begin only one treatment at a time. A trial of effective medication may subsequently help patients with anxiety and affective disorders be better able to participate in a dynamic therapy, if such is indicated, and help focus the therapeutic goals of that treatment. Let me illustrate the benefits of sequencing treatments with another clinical example.

Clinical Case

Ms. F was a 26-year-old medical intern who was self-referred and presented for consultation with the complaint of obsessive checking that was "making my work hell." The patient reported that she remembered being extra careful about things toward the end of high school, always checking and rechecking, making sure that her homework was in her bookbag, checking the setting on her alarm clock three times, opening her bookbag three times to make sure that she brought the right book home from school. Most of the obsessive checking was school-related. Though these habits exasperated her friends and family, she was not otherwise obsessive and did not lead a restricted life. Quite the contrary: she was very social and spontaneous and enjoyed a wide range of activities including varsity sports and the theater club.

After high school Ms. F went to a prestigious university, but again compulsive checking—of the class schedule, papers, the spellcheck function on her computer—led to an increasing sense of frustration and helplessness. For the first 2 years of medical school the checking and rechecking patterns continued, but in this setting she was seen as hard-working, careful, and conscientious. She was a straight-honors student but inwardly realized that she could not "break the grip of this" and was frightened and, at times, panicky. When she began her clinical rotations, her performance began to deteriorate because

she could not work fast enough; her case presentations were poor because she was too inclusive and was never able to get to the point.

The outstanding reputation that she had earned in her first 2 years of medical school carried her through her clinical years, but when she began her internship, life began to fall apart. She was unable to leave the hospital because she believed that her patients' laboratory reports were not sufficiently checked, and when she did manage to go home she was in agony because of the certainty that she had left something undone and that harm would come to one of her patients. She was no longer a bright star, but an intern with whom neither the residents nor medical students wanted to work. She was increasingly depressed, frustrated, and anxious.

At the time she presented for consultation she had been involved with a man, a fellow medical student, for 2 years, but this relationship had been markedly strained by her increasing irritability and depression. With almost palpable pain and pleasure she told of a vacation they had taken together 2 months prior to seeking treatment; they both enjoyed themselves and she felt quite loving and cared-for. The phenomenology of the patient's symptoms met DSM-IV criteria for obsessive-compulsive disorder and I suggested that medication could be of help. She revealed that since her second-year psychiatry course she had believed that she had some type of obsessive-compulsive syndrome and had wanted to "get the nerve to try medication." I also commented that it was striking that her obsessions and compulsions restricted her career. It was agreed that she would begin with a trial of medication and we would reevaluate after a number of months. With medication Ms. F's obsessive-compulsive pathology diminished markedly. Her checking behaviors were not totally absent but became much more manageable and she no longer had the fantasy that if a patient were admitted to her care she would be trapped in the hospital forever.

Ms. F continued on medication alone for 4 months and then asked to see me again. She had now begun her residency and wanted to talk about success. Specifically, she felt that being freed of the compulsive rituals had changed the question from whether or not she would fail to: how good could she really be? In subsequent sessions, competitive themes and what can be generically described as oedipal conflicts emerged. I recommended that she begin analysis, to which she agreed, and she entered analytic treatment—still on medication.

What were the origins of this patient's obsessive symptoms? Were the checking behaviors and the oedipal conflicts significantly related? At that point I did not know and, quite frankly, even with the analysis completed, I'm still not sure that I know. But most importantly, I did not think that I *had* to know in order to recommend medication treatment. Medication would provide the most direct relief from the obsessive symptoms; that was the basis for its recommendation. Furthermore, medication allowed the patient to enter analysis focused on dynamic issues instead of the immediate relief of symptoms. Did the medication create a "false self" or did it allow the patient to pursue the vocational, interpersonal, sexual, and psychological pleasures and achievements that she was capable of? I believe that the latter is true, both of the medication and the analysis.

Clinical Recommendations

Not surprisingly, there has been to date no systematic study of combining medication with psychodynamic psychotherapies. Studies in progress are focused on comparing psychodynamic treatments to medication, not assessing the possible synergistic benefit of their combination. In the absence of systematic data, we are left to base our recommendations on clinical experience.

For which patients should one consider combining medication and psychodynamic treatments? In the course of initial evaluation a psychodynamic therapist must not only assess the indications and suitability of the patient for psychodynamic treatment but must perform a phenomenological diagnostic assessment as well. In all patients who meet DSM-IV criteria for depression or anxiety disorder, the therapist should consider the use of medication. This is not simply a therapeutic but an ethical imperative, since psychodynamic treatments have the most limited evidence of efficacy in affective and anxiety disorders compared to medication treatments or to forms of specific psychotherapy such as interpersonal or cognitive-behavioral therapy. A clinician has the responsibility to discuss all proven, effective treatment options even if they are not among the treatments that the clinician happens to administer.

The question of medication use is much more difficult in patients with subsyndrome affective and anxiety disorders. Though growing clinical experience and some data from controlled trials suggest that medication can help many such patients, it would be premature to suggest that all such patients should receive a trial of medication (Philipp 1992).

If medication is to be prescribed, who should supervise this part of the treatment? Obviously, if the psychodynamic therapist does not have an M.D. degree, medication must be administered in collaboration with a pharmacological consultant. This raises issues surrounding the consultation process and split treatment, issues about which much has been written and which are beyond the scope of this chapter. If the psychodynamic therapist does have an M.D., there is the possibility that he or she will prescribe the medication. In the case of a medical therapist doing psychoanalytic psychotherapy, I strongly believe that it is preferable that the therapist prescribe and follow the medication, albeit with the continued availability of a psychopharmacological consultant. The technique of psychoanalytic psychotherapy allows for the kind of active intervention inherent in the medical model necessary to ensure the efficacy and safety of medication treatment. The question is more complex if one considers giving medication in combination with psychoanalysis. Though medication and psychoanalysis are compatible treatments, the question remains: is the *prescribing* of medication compatible or discordant with analytic technique? The psychoanalytic relationship between therapist and patient is at odds with the more active doctor-patient relationship that is necessary for the effective and safe prescription of psychotropic medication. This incompatibility can be illustrated by reviewing the procedure for prescribing antidepressants. First, there should be full and direct explanation of anticipated side effects, and the patient's questions should be answered directly and completely. Once medication is begun there may be frequent phone contact in order to monitor side effects before increasing a dose. Further, one cannot wait for the patient to report certain material; there is a checklist of symptoms that the doctor must review. New questions from the patient need to be answered directly and there may be need for ortho-

static blood pressure readings, arrangements for plasma level measurements, and so on. Although a psychoanalyst may see a patient frequently, this does not mean that the patient will be so accommodating as to begin the analytic session with a review of their bowel and bladder productions and a Hamilton Rating Scale—the kind of data necessary to monitor safety and to evaluate therapeutic response to medication. In order to be an effective pharmacologist, the analyst has to repeatedly abandon technical neutrality, thus disrupting the analytic process.

Given these considerations, I believed for a long time that the analyst should not administer medication. However, having heard of more cases where the analyst and pharmacologist are one, I think that my original view represented a certain type of analytic prejudice against medication. Sometimes there are parameters (i.e., modifications in standard technique) that an analyst feels are necessary to introduce into the analysis, or parameters that are imposed by external circumstances. Medication can be considered such a parameter; there is no compelling reason to consider it so special that the analyst should not control it and analyze the patient's reaction to it as with any other parameter.

Perhaps the most compelling issue is timing. If the psychodynamic therapist, working within a model that allows multiple perspectives, does a diagnostic evaluation, then the question of medication arises after the initial evaluation. However, in the face of what is perceived as a decreasing pool of patients interested in long-term psychodynamic treatments, many psychodynamic therapists may be afraid of "losing" the patient to effective medication treatment. Actually, one of the most effective ways to develop a psychodynamic or even a psychoanalytic practice is to be able to effectively use medication. This increases the pool of patients available for psychodynamic treatments and does much to create a positive therapeutic alliance.

Although it may increasingly be the case that medications are considered during the process of initial evaluation, perhaps a majority of medication treatments are still considered, or initiated, in the midphase of psychodynamic treatment. In this case the recommendation for medication, albeit correct in terms of diagnosis, is invariably permeated with countertransference, which often pre-

cludes the successful combination of medication with dynamic treatment. If the clinician considers medication treatment in the course of an ongoing therapy, she or he must consider this an indication of countertransference independently of whether medication is appropriate. Most frequently it is the therapist's frustration with (or reaction to the patient's frustration with) the persistence of symptoms despite what is perceived as good process and accurate interpretation which leads to the recommendation for medication. The unexpressed meaning to the analyst of "turning the treatment over" to a medication is potentially devastating. If the therapist believes that psychological treatment is always preferable to medication, which is only to be considered when psychotherapy has failed, then the therapist may turn to medication not only out of frustration but, perhaps most importantly, with a tacit sense of defeat. In such situations the recommendation for medication, albeit correct, does not sufficiently address problems in the treatment; medication is not a substitute for a more encompassing treatment consultation, if such is necessary.

Suggesting medication in the middle of a dynamic treatment also has multiple meanings to the patient, prominent among which may be that the recommendation for medication is a reflection of their failure to work effectively in psychotherapy. If only they were "good enough," they feel, or had sufficient strength of character, they would not need medication; they would be able to "do it on their own." If the patient interprets the recommendation for medication as proof that the therapist is giving up on them, then outrage, despair, and relief may all be expressed. One of the ways in which anger is commonly expressed is though a pointed query: if the therapist thinks that a medication is indicated and would be helpful, why is it only now being recommended? Why didn't the therapist suggest it previously, especially since the symptoms have been chronic? The answer is most often found though analysis of the countertransference.

Conclusion

The desire to use medication in combination with dynamic therapies means that psychodynamic clinicians have had to reach

outside of their theoretical framework and utilize phenomenologically defined diagnostic systems. For medication and psychodynamic therapies to be effectively combined, phenomenology and metapsychology should be understood in parallel. To place them in a hierarchy or simply juxtapose them to each other does not result in integration of theory but only serves to create a mind-body dichotomy. If psychodynamic clinicians listen to their patients who are on medication they will often hear the echoes of theoretical conflicts that they thought had been resolved. If these two forms of treatment are to be truly integrated, then psychodynamic metapsychology must be revised to recognize affects as not simply manifestations of psychic conflict, but rather as powerful and primary forces in determining both behavior and the organization of psychic structures. We also must not confuse affects with affective disorders nor anxiety with anxiety disorders. If we are ever to have a theoretical integration that will serve as a meaningful underpinning to our clinical practice, we must appreciate that character structure and intrapsychic phenomena such as defense mechanisms are state dependent. Depression and anxiety do not simply reflect intrapsychic and interpersonal events; they also create them. It is hoped that at some point our theory will catch up to what pharmacologists, psychodynamic clinicians, and patients alike have already observed: that effective medication treatment in combination with psychodynamic therapy often does more than treat the illness: it changes the person.

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Chapter 3

Integrated Treatment Planning for Borderline Personality Disorder

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Introduction

New evidence (Bender et al. 2001) confirms what practicing psychiatrists already knew well—that patients with borderline personality disorder (BPD) are often severely disabled and use treatment resources extensively. It is estimated that 15%–25% of the psychiatric clinical population has BPD (Gunderson and Zanarini 1987), frequently comorbid with other Axis II disorders and with various Axis I disorders. The social and occupational costs and family stress levels associated with BPD are substantial. Further, recent data reveal that patients with BPD use significantly more psychotropic medication and most forms of psychosocial treatment than do patients with certain other personality disorders and with major depressive disorder (Bender et al. 2001).

In spite of the extensive use by patients with BPD of medication and other treatments, knowledge about the appropriateness or effectiveness of these treatments in general clinical practice has derived, until recently, almost exclusively from anecdotal clinical reports. New data are emerging, however, on psychotherapy and pharmacotherapy for BPD, including data from randomized controlled studies. The American Psychiatric Association (APA) is developing a practice guideline for borderline personality disorder (American Psychiatric Association, in press), the first practice guideline for any of the personality disorders. Based on a synthesis of published controlled treatment studies, along with the "best

practice" consensus of expert clinicians, this practice guideline recommends combined psychotherapy and pharmacotherapy for patients with BPD. This recommendation is consistent with published reviews of the effectiveness of psychotherapy for BPD (Perry and Bond 2000) and pharmacotherapy for BPD (Soloff 2000).

Assessment

Several questions need to be answered before specific treatment recommendations can be made for a given patient.

What Type of BPD Is Present?

Clarkin reported that there were 56 different ways in which a patient could be diagnosed with BPD by the eight polythetic criteria of DSM-III (Clarkin et al. 1983), and this number would be even greater with the nine criteria of DSM-IV-TR. (A text revision of DSM-IV, referred to as DSM-IV-TR, has recently been published.) The DSM-IV-TR criteria for BPD (American Psychiatric Association 2000) are listed in Table 3–1.

Clearly, BPD is not a single condition but a category of disorder that includes many subtypes. DSM-IV-TR characterizes the prototypic patient with BPD as displaying "a pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following [nine criteria]" (American Psychiatric Association 2000). When conceptualized as a condition residing on a spectrum of disorders, BPD is usually included on both the affective spectrum and the impulsive spectrum (Siever and Davis 1991).

The concept *borderline* employed in the DSM-IV-TR definition of BPD is to be distinguished from that used in *borderline personality organization*, a theory of intrapsychic structure developed by Kernberg (1975). Kernberg's use of the term implies an umbrella concept which groups BPD with certain other DSM-IV personality disorders, including schizoid PD, antisocial PD, and narcissistic PD, based on these disorders' presumed common characteristics of identity diffusion, use of primitive defense mechanisms, and overall maintenance of reality testing (Koenigsberg et al. 2000).

Table 3–1. Characteristics of borderline personality disorder

A pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

(1) Frantic efforts to avoid real or imagined abandonment. **Note:** Do not include suicidal or self-mutilating behavior covered in Criterion 5.
(2) A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation.
(3) Identity disturbance: markedly and persistently unstable self-image or sense of self.
(4) Impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating). **Note:** Do not include suicidal or self-mutilating behavior covered in Criterion 5.
(5) Recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior.
(6) Affective instability due to a marked reactivity or mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days).
(7) Chronic feelings of emptiness.
(8) Inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights).
(9) Transient, stress-related paranoid ideation or severe dissociative symptoms.

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The etiology of BPD remains unknown. Indeed, it would probably be more appropriate to refer to the *etiologies* of BPD, since it seems likely that there are multiple etiologies of this heterogeneous group of conditions (Paris 1994; Zanarini 1997; Zanarini and Frankenburg 1997). Theoretically, one might expect that different etiologies could lead to different predominant symptom

patterns, hence different types of BPD. Five etiology-based BPD subtypes are suggested below.

Type 1: Affective

Etiological theory Akiskal and colleagues proposed that BPD represents a "subaffective" disorder (Akiskal 1981; Akiskal et al. 1985). This type of BPD would presumably be conceptualized as a moderately heritable vulnerability state, precipitated by environmental stress (Paris 1999).

Presumed prototypic criteria Affective borderline subtypes would show a predominant symptom cluster characterized by the following DSM-IV-TR criteria:

- Criterion 6: Affective instability due to marked reactivity of mood (dysphoria or anxiety)
- Criterion 5: Recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior

Type 2: Impulsive

Etiological theory Zanarini (1993) proposed that BPD is best conceptualized as an impulse spectrum disorder, sharing with other disorders of impulse control (such as substance use disorders or antisocial personality disorder) a propensity to action. This view is shared by Hollander (1993), Siever (1996), Links and Heslegrave (2000), and others.

Presumed prototypic criteria Impulsive borderline subtypes would show a predominant symptom cluster characterized by the following DSM-IV-TR criteria:

- Criterion 4: Impulsivity in at least two areas that are potentially self-damaging
- Criterion 5: Recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior

Type 3: Aggressive

Etiological theory Kernberg (1975) proposed that patients with BPD are driven by an excess of aggression that could reflect a pri-

marily inherited aggressive temperament. Alternatively, excessive aggression could be correlated with reduced central nervous system serotonin levels (Siever 1996) or could be a secondary reaction to early life experience of trauma and abuse (Zanarini 1997).

Presumed prototypic criteria Aggressive borderline subtypes would show a predominant symptom cluster characterized by the following DSM-IV-TR criteria:

- Criterion 8: Inappropriate, intense anger or difficulty controlling anger
- Criterion 6: Affective instability due to marked reactivity of mood (irritability)

Type 4: Dependent

Etiological theory Masterson (1972) and Masterson and Rinsley (1975) proposed that parental intolerance of the development of autonomy in the preborderline child, due to separation-resistant pathology in the parent or parents, could lay the foundation for BPD.

Presumed prototypic criteria Dependent borderline subtypes would show a predominant symptom cluster characterized by the following DSM-IV criteria:

- Criterion 1: Frantic efforts to avoid real or imagined abandonment
- Criterion 6: Affective instability due to marked reactivity of mood (anxiety)

Type 5: Empty

Etiological theory Adler and Buie (1979) and Adler (1985) proposed that inconsistency and lack of empathy in early parenting of the preborderline child could interfere with the establishment of basic trust, with resultant failure to develop an evocative memory of a good, nurturing internal object.

Presumed prototypic criteria Empty borderline subtypes would show a predominant symptom cluster characterized by the following DSM-IV-TR criteria:

- Criterion 7: Chronic feelings of emptiness
- Criterion 3: Identity disturbance: markedly and persistently unstable self-image or sense of self

Comments on the Five-Type Etiological Model

Criteria other than those listed above, such as cognitive deficits or intermittent difficulties with reality testing (reflecting the ninth diagnostic criterion, added in DSM-IV), could also predominate in some type or types of BPD. The above scheme is, therefore, not comprehensive. However, studies are beginning to appear in the literature that will help test at least some of these etiological theories (Gunderson 2001; Zanarini 1997).

Although evidence is not available that confirms the validity of these presumptive correlations between theoretical etiologies and predominant symptoms, this model can be helpful as a way to conceptualize different types of BPD and to plan appropriate treatment accordingly.

What Type of Comorbidity Is Present?

It is well established that comorbidity within Axis II is common (Oldham et al. 1992). However, the treatment implications of intra–Axis II comorbidity are variable, and the appropriateness of the very concept of comorbidity (i.e., of the presence of independent, coexisting disorders) erodes with increasing numbers of diagnosable Axis II disorders in a given patient. Oldham and Skodol (2000) recommended that a single diagnosis of *extensive personality disorder* be given when a patient is above threshold for three or more DSM-IV Axis II disorders. In such cases predominant symptom patterns become the most important guides to treatment planning, as discussed below, with preservation of the patient's safety and capacity to participate in an active treatment program being the highest priorities.

Axis I–Axis II comorbidity is also common (Gunderson 2001; Oldham et al. 1995; Pfohl 1999), and it is widely reported that when treatment is provided for many Axis I conditions, the coexistence of Axis II pathology complicates and, often, prolongs treatment. Ruegg and Frances (1995) reported that in

10 of 13 studies reviewed, the presence of personality disorders worsened the outcome of treatment of Axis I conditions. Historically, however, studies of major Axis I mental illness have not assessed or controlled for the presence of Axis II conditions; some discrepancies in results in Axis I treatment studies could, therefore, be due to undetected differences in Axis II comorbidity. There are now many semistructured interviews available for both Axis I and Axis II, and it is important that systematic evaluation of psychopathology on both axes be carried out.

How Amenable to Treatment Is the BPD in Question?

Since BPD is a heterogeneous construct that encompasses many subtypes, some BPD patients will be more amenable to treatment than others. Stone (2000) described a series of positive prognostic factors—including high intelligence, artistic talent, and self-discipline—that have been correlated with more favorable treatment outcome. Stone also described characteristics—including intrusive behavior, bitterness, indiscretion, vengefulness, callousness, and psychopathy—which, when prominent among the symptoms of a patient with BPD, make the patient less amenable to treatment. Table 3–2 lists a number of factors generally described as negative prognostic variables.

Table 3–2. Negative prognostic variables for borderline personality disorder

Affective instability, magical thinking, and aggression in relationships (McGlashan 1985, 1992)
Impulsivity or substance abuse (Links et al. 1993; Stone 1993)
Childhood sexual abuse (Paris et al. 1993)
Incest (Stone 1990)
Earlier age at onset (Links et al. 1993)
More chronicity (McGlashan 1992)
Greater severity (Links et al. 1998)
Schizotypal features (McGlashan 1985)
Antisocial features (Stone 1993)

As many of these features are common in patients with BPD, practitioners experienced with borderline patients often make guarded prognoses. However, longitudinal studies consistently indicate that many BPD patients improve dramatically over time (Gabbard 2000b).

How Motivated for Treatment Is the Patient?

A patient may appear to be motivated for treatment, but the presence of many negative prognostic factors such as those listed in Table 3–2 should alert the clinician to proceed cautiously, especially if significant psychopathy is present. However, some patients may not have prominent negative prognostic factors but still be poorly motivated for treatment. The expectations of therapy held by patients with BPD (usually unconsciously) can lead to initial idealization of the therapist; unrealistic fantasies of being rescued masquerade as motivation to embark with the therapist on a partnership experience. In such cases, vast and swift changes can occur in the nature of the therapeutic interaction at the first point in treatment when the therapist does not measure up to the patient's unrealistic and unconscious expectations; this can be quite challenging.

Clinical Case

Ms. G, a 29-year-old single woman, was referred for intensive psychotherapy by her former therapist, whom she had seen sporadically for the previous 7 years. The patient was a freelance writer who had lost many jobs due to her emotional volatility and interpersonal difficulties. Among her presenting complaints were that she 1) always made the wrong decisions, 2) sabotaged all potential romantic relationships, 3) was prudish about sex (having been sexually active with only one man and never orgasmic), 4) was uncertain about her long-term career goals, 5) vacillated between insecurity about her abilities and contempt for other writers, 6) had "spoiled" her appearance and health by her own stubborn behavior, 7) was incapable of being assertive or aggressive (although she occasionally had "temper tantrums"), and 8) had a chronic sense of emptiness and lack of feeling fulfilled. There was no history of suicidal or actively self-injurious behavior.

The patient was diagnosed with no disorder on Axis I and with borderline, histrionic, and passive-aggressive personality disorders on Axis II. The patient had no major negative prognostic characteristics and seemed highly motivated for treatment. Using the above typology, she would have been initially classified as predominantly Types 4 and 5 BPD, since her demeanor was entirely cooperative and she emphasized that she was unable to act aggressively, even when it would be to her advantage to do so.

Ms. G began intensive individual psychotherapy, three times weekly, with a psychiatrist. Active symptoms that might have benefited from medication were not apparent. For several months, the patient appeared to be engaging effectively in the therapeutic process; she never missed sessions, was never late, and spoke freely of her interpersonal anxieties and difficulties in a self-critical style. However, after several months of work the patient somewhat abruptly informed the therapist that she had suddenly realized that she was demonstrating with him one of the very types of behavior that got her in trouble. "I have been going along merrily here, telling you my life's story, without any thought about whether I should trust you," she stated. "I've realized that I don't know anything about you and, typically, I haven't checked out your qualifications." The patient proceeded to grill the therapist about his training, insisting on knowing exact details of his education.

The therapist responded with selected information that he felt was reasonable, for example, that he was a board-certified psychiatrist. Earlier, one of the patient's complaints about herself had been that she had foolishly attended the wrong college; with this in mind, the therapist suggested that it might be of more value to explore the patient's concerns as such than to actually review the therapist's credentials in detail. The patient became quite angry and stated that the therapist must have attended "one of those fly-by-night offshore schools" and that she had—once again, through her own lack of vigilance—landed in the hands of ineptitude. The patient became unshakably convinced that the therapist was "stupid, with only one or two worn-out ideas rattling around in your empty head," and for some time, no matter what the therapist said, would reply that it was "the stupidest, most idiotic statement I have ever heard!" Often she would lapse into contemptuous silence, clearly seething with rage, and when the therapist indicated his assumption that she was nonverbally continuing her critique of him, as if there was no point in saying anything, the patient would explosively agree.

The therapist felt that the profound discrepancy between the patient's view that she could not express aggression and her actual behavior in session represented a primitive form of denial, and he recommended a low-dose antipsychotic medication. The patient, however, rejected this suggestion. The therapist obtained expert consultation to help deal with his countertransference and eventually was able to make some progress by underscoring the inconsistencies between the patient's behavior (regular, steady attendance at all sessions) and her words (that she was speaking to an idiot), leading to the beginnings of an exploration of the projected internal world of the patient.

This case highlights only a few of the many issues that arose during the intensive treatment of Ms. G and is presented here to illustrate the importance of listening carefully to all aspects of the patient's history and of remaining cautious even if the induction phase of treatment seems to be going smoothly—especially given a history of stormy interpersonal relationships. It also illustrates that although adjunctive pharmacotherapy may not be possible when indicated, productive work can still be done. Medication may become an option later in treatment.

Many experienced therapists advocate that a contract be established in the early phase of treatment, to serve as a benchmark for future reference (Akhtar 1995; Clarkin et al. 1999; Gunderson 2001; Kernberg et al. 1989; Linehan 1993; Yeomans et al. 1992). Such a contract is an agreement between patient and therapist about the goals of treatment and the respective responsibilities of each party. In addition to specifying frequency and length of sessions, fee, billing procedures, management of vacations and missed sessions, and other pragmatics, contracts often address how emergencies will be handled, minimal conditions essential for therapy to be possible, and the like. The APA Work Group that developed the BPD practice guideline chose not to use the term "contract," concerned that inexperienced therapists might place undue reliance on this early "rules-of-treatment" discussion, but referred instead to "establishment of the treatment framework" (American Psychiatric Association, in press). The most predictable thing about the establishment of such a framework with most borderline patients is that the agreement will be

tested and challenged. For this very reason, establishing such a framework or contract early in treatment provides an opportunity to review it and refer to it at later stages of treatment.

Developing a Biopsychosocial Treatment Plan

After it has been clearly established that a patient has BPD and seems amenable to and motivated for treatment, an integrated, biopsychosocial approach to treatment *planning* involves careful consideration of psychotherapy *and* pharmacotherapy. The following seven steps can be useful in systematically developing such a treatment plan.

Step 1: One Therapist or Two?

Since in most cases treatment will involve a combination of psychotherapy and symptom-targeted pharmacotherapy, it is important to establish as part of the treatment framework who will provide the psychotherapy and who will prescribe the pharmacotherapy. If the psychotherapist is a psychiatrist, a decision needs to be made whether the psychiatrist will be both psychotherapist and pharmacotherapist or whether these roles will be separated and handled by two collaborating clinicians. Opinions are divided on whether there is a preferred model (Gabbard 2000a); the decision may ultimately be determined by what the psychiatrist or the patient is most comfortable with. Those preferring the single-treater model argue that it prevents the risk of splitting—a common BPD defense—and that potential miscommunication is avoided. Those advocating two therapists argue that necessary time spent on monitoring symptoms to adjust dosages and minimize side effects detracts from the therapy itself and is better handled by a psychopharmacologist dedicated to this task alone. Of course, if the primary therapist is not a physician, the two-treater model is a necessity. In this case, however, it is preferable to have a partnership in place at the outset of treatment so that the patient understands these arrangements as part of the treatment framework. Even in cases where the patient has

no obvious current symptoms which might benefit from pharmacotherapy there is usually a history of such symptoms; thus, the nonprescribing therapist may wish to arrange an initial consultation with a prescribing colleague so that pharmacotherapy can be initiated readily if indicated. If a patient adamantly opposes taking medication it might still be possible to arrange a consultation so that as therapy proceeds this option is in place if the patient accepts it.

Step 2: Consideration of Axis I

A careful evaluation of the patient with BPD for comorbid Axis I conditions is crucial. For example, the treatment of BPD patients with comorbid active substance use disorder will be complicated, and prioritized attention may need to be given to the substance use before effective work can be done on the borderline personality disorder itself. Other comorbid Axis I conditions, such as a current major depressive episode, may also dictate emphasis on the Axis I condition itself—either at the outset of treatment (if the patient is highly symptomatic with that condition) or at any time in treatment when the Axis I disorder flares up. A current Axis I condition will be of more pressing concern than evidence of past Axis I illness (although that information, too, is important).

Clinical Case

Ms. P, a 32-year-old, divorced, childless woman, was referred for treatment because of depressive episodes and a chronic dysphoric state of anger and bitterness. A medical professional who was productive at work, she nevertheless had few friends and an unsatisfying social life. Her one sibling, a younger sister, had recently married; the patient's apparent profound envy manifested itself as sarcastic, venomous criticism of the sister. According to the patient, her own marriage had failed due entirely to her former husband's infidelity. The patient spoke of her former husband derisively, yet admitted that she had been initially infatuated with him. She could see no explanation for his infidelity, nor any contribution from her to problems in the relationship. Shortly after her marital separation 5 years previously, the patient became extremely depressed, though never

suicidal. She did not seek treatment but arranged to obtain antidepressant medication from a colleague at work. After several months, her mood improved and she discontinued the medication. She had no further major depressive episodes but acknowledged having bleak days laced with anger and hopelessness. Although she never attempted suicide, she occasionally confided to a co-worker that she might as well kill herself. She sought treatment because of increasing unhappiness and irritability, which was beginning to interfere with effective work functioning. The patient's provisional diagnoses were major depressive disorder in partial remission and borderline personality disorder.

Twice-weekly individual psychotherapy was arranged. The patient soon described feeling better and reported interest in a man she knew at work. She began to spend time with him socially and, although she described their sexual relationship with contempt, determined to marry him. Preoccupation with this new relationship consumed the patient in therapy hours with an almost predatory quality. When asked by the therapist whether she might be prematurely rushing into a relationship with a questionable future, she dismissed this possibility with no interest or insight. When the man rejected her, she caustically categorized him as totally worthless and undesirable and within weeks developed a major depressive episode. The therapist recommended antidepressant medication, which she agreed to take; nonetheless, the patient's depression deepened, she began to lose weight, she spoke of suicide, and she missed many days of work. The therapist insisted that the patient be hospitalized, but the patient refused, stating that it would ruin her career forever. The therapist indicated that in that case he would have to hospitalize her involuntarily; she then bitterly agreed, blaming the therapist for ruining her career. In fact, the treatment received over several weeks in the hospital, including some adjustment in her medication, was effective. Her depression remitted and she was discharged, successfully returning to work.

After 6 months of twice-weekly therapy, during which the therapist attempted to help the patient recognize some of her own contributions to her interpersonal difficulties, the patient swept dramatically into the therapist's office and demanded to be hospitalized lest she kill herself. When the therapist appeared willing to consider admitting her, the patient then refused hospitalization. The therapist interpreted these fireworks as reactions to transference; the patient, driven by her increased

reliance on him and rage at the limits of his availability, felt a need to render him impotent. The patient did not need to be hospitalized, and the therapeutic work continued with no self-endangering behavior or further suicide threats.

This clinical example illustrates several points in working with borderline patients who have comorbid diagnoses on Axis I. In this case, the patient had many of the affective symptoms of BPD, which can be difficult to differentiate from symptoms of major depressive disorder (MDD). Gunderson and Phillips (1991) and Rogers et al. (1995) have discussed the differentiation of these two types of symptom patterns; Table 3–3 contrasts symptoms of Axis I depression with depressive components of BPD.

Table 3–3. Clinical features of depression as a component of borderline personality disorder compared with depression alone

Depression with borderline personality disorder	Depression without borderline personality disorder
Marked shifts from one dysphoric mood to another	Pervasive loss of interest in activities or sex
Mood remains reactive to environmental stimuli	Mood is not reactive; no rapid shifts
Binge eating and purging	Weight loss or gain without bingeing or purging
Blaming of others	Feels worthless and blames self
Impaired concentration secondary to drug usage	Impaired concentration secondary to depression
Impulsive suicide attempts without thoughts of death	Recurrent thoughts of death and suicide precede suicide attempt
Chaotic functioning between episodes	Only mildly depressed between episodes
Melancholic features absent	Melancholic features present
Irritability and subjective agitation	Objective psychomotor agitation or retardation
Clear precipitant for depression (often involving rejection)	Lack of obvious precipitant
Loneliness, emptiness, and boredom	Guilt, remorse, and acute failures of self-esteem
Inner sense of badness, deprivation, and conscious rage from early life	

Ms. P showed reactive affectivity as part of her BPD, as well as subthreshold symptoms of MDD at the initiation of treatment. Highly reactive suicidal ideation occurred at a later stage of outpatient treatment, but without the endogenous depressive features that characterized the prior episode. An additional point is that when a patient with BPD develops an exacerbation of a coexisting Axis I illness, the patient continues to experience personality disorder symptoms. Hence, this patient, even while severely depressed, characteristically externalized her problems.

Step 3: Psychotherapy

The mainstay of treatment for BPD is psychotherapy. Clinical reports in the literature abound which recommend types of psychotherapy for borderline patients. It is generally accepted that effective psychotherapy for borderline patients cannot be accomplished in a brief time frame (American Psychiatric Association, in press), making it methodologically challenging to carry out controlled studies. Nevertheless, randomized controlled studies have been reported for a form of cognitive-behavioral therapy known as *dialectical behavior therapy* (DBT; Linehan et al. 1991, 1993, 1994, 1999b), as well as for a psychodynamically oriented treatment program in a partial hospital setting (Bateman and Fonagy 1999). Although the numbers of participants in these studies are small, limiting generalizability, the results are encouraging. It is increasingly clear that carefully designed and structured treatment, individually tailored for the particular type of borderline patient (Horwitz et al. 1996), is appropriate, whether the psychotherapy employs a cognitive-behavioral or a psychodynamic approach. Selection of a particular approach may be determined by the training and skills of the available therapist, and there may be a number of different treatment approaches with potential to benefit any given patient. Careful analysis of cognitive-behavioral and psychodynamic approaches reveals that in spite of differences in theoretical bases (e.g., learning theory versus psychodynamic theories of etiology) and in technique, there are many similarities among most of the treatment approaches in practice. DBT, for example, selects "parasuicidal" borderline patients and targets suicidal, life-threatening, or self-injurious

behavior as a high priority early in treatment, followed by attention to "therapy-interfering behavior" and then to "quality-of-life–interfering behavior" (Linehan 1993; Linehan et al. 1999a). Therapists using a psychodynamic approach similarly prioritize high-risk (e.g., suicidal or homicidal) behavior, followed by issues that threaten to interrupt treatment, breaches of the "contract," and the like (Clarkin et al. 1999). Table 3–4 lists elements that occur in most forms of effective psychotherapy for BPD.

Some form of group work is generally recommended, combined with individual psychotherapy. A group skills-training approach is often used and other forms of group therapy can be used as well, such as interpersonal group therapy (Gunderson 2001). Some treatment programs encourage formally scheduled weekly meetings of therapists, an arrangement thought to provide peer support and to enhance the skills of treaters.

The usefulness of family therapy in the treatment of patients with BPD is less clearly delineated in the literature. Families are not always available or willing to be involved in treatment. When borderline patients are, however, in regular contact with their families, a psychoeducational approach has been recommended (Gunderson 2001). In cases where borderline patients are enmeshed in families in ways that contribute to the perpetuation of symptoms, it may be appropriate to engage the family in more traditional dynamically oriented family therapy (Shapiro et al. 1977).

Table 3–4. Common features of recommended psychotherapy for borderline personality disorder

Nonbrief
Strong therapeutic alliance
Establishment of clear roles and responsibilities of patient and therapist
Active therapist
Hierarchy of priorities
Empathic validation plus need for patient to control behavior
Flexibility
Limit setting
Concomitant individual and group approaches

Step 4: Pharmacotherapy

Soloff (1998) itemized a set of principles to guide the psychopharmacologist in providing symptom-targeted psychopharmacology for personality disorders in general, including BPD. These principles are shown in Table 3–5.

Increasing numbers of reports have been appearing which evaluate psychopharmacologic treatments of BPD. These studies range from randomized controlled studies to open clinical trials and have been reviewed by Soloff (2000). A set of three medication algorithms has been developed, based on the controlled studies in the literature (Soloff 2000; American Psychiatric Association, in press). These three algorithms are aimed at predominant clusters of cognitive-perceptual, affective-dysregulatory, or impulsive-behavioral symptoms; and they track responsiveness in three categories: effective, partially effective, or not effective. In cases where medication is effective, limited time periods are generally recommended for such medication, and in cases where medication is only partially effective, augmentation strategies are proposed. When there is no effect, switching to a different medication is proposed.

Table 3–5. Symptom-oriented psychopharmacology for personality disorders (PDs)

Symptom-specific treatment in patients with PDs is a rational and efficient means of optimizing and stabilizing function.
There is no one treatment of choice for each defined personality dimension.
Clinical effects are modest.
Medications do not cure character pathology.
Duration of treatment is clinically defined and depends on whether the target symptom is a stress-related state symptom or a trait vulnerability.

Source. Adapted from Soloff 1998.

Step 5: Combined Psychotherapy and Pharmacotherapy

There is now a strong consensus that psychotherapeutic treatment of BPD should be augmented with symptom-targeted pharmacotherapy (American Psychiatric Association, in press; Gabbard 2000a; Koenigsberg 1991). Early notions that medications would interfere with psychoanalytically oriented treatment by reducing anxiety and decreasing the patient's motivation to understand unconscious and presumably anxiety-producing material are now discredited. Yet the degree to which medication will be accepted by the patient will vary, and the relative importance of medications in treatment of patients with BPD will vary depending on the type of BPD in question. Figure 3–1 shows a hypothetical distribution of the relative balance of psychotherapy and pharmacotherapy, based on the theory-based typology of BPD described above. In all cases, combined treatment is recommended, but the relative importance of psychotherapy and pharmacotherapy could differ, as shown.

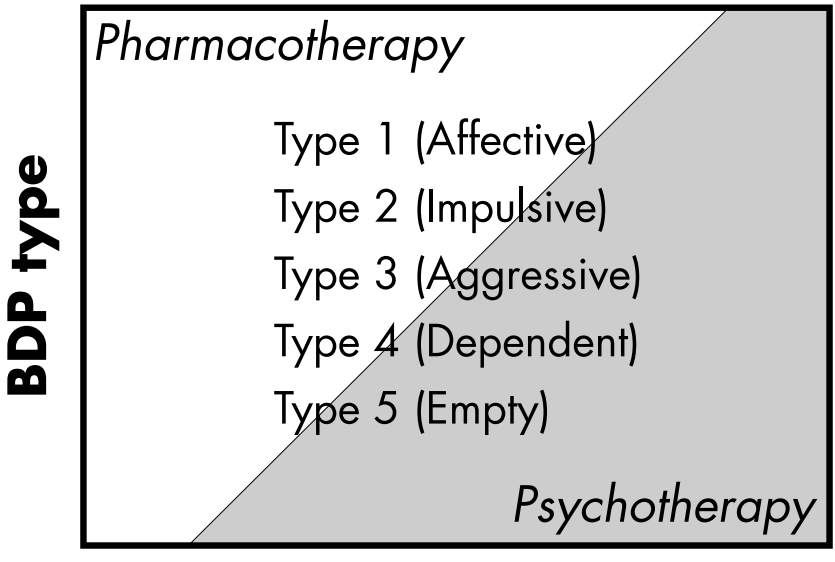

Figure 3–1. Balance of combined treatment according to borderline personality disorder type.

Step 6: Crisis Management

Of paramount importance in developing a treatment plan for a patient with BPD is to have an understanding with the patient regarding crises (Clarkin et al. 1999; Gunderson 2001). Some types of behavior, such as suicidal or self-injurious behavior, will frequently be on the list of potential crises, although not all patients with BPD engage in these behaviors. Other types of crisis include violent or threatening behavior toward others and disinhibited, disruptive, or self-endangering behavior due to substance abuse. A careful history will usually reveal previous episodes of these types of behavior, although they may be denied by the patient and only identified through collateral information sources. If significant substance abuse is present, essential initial steps in treatment planning may be inpatient detoxification and/or enrollment in a 12-step program or other substance-abuse treatment program. Such an approach is sequential in that it focuses on the substance abuse first, then on the symptoms of BPD. Drake et al. (1997) have recommended integrated treatment, rather than sequential or parallel treatment, for patients with coexisting substance abuse and major mental illness; however, studies are not available for patients with coexisting substance use disorder and BPD which might clarify the potential advantages of such an approach. Also, therapists experienced in treating BPD may not be experienced in treating substance abuse.

A more subtle, but still important, consideration in treatment planning for BPD is the *anticipation* of crises. Patients with BPD with affective dysregulation or impulsive dyscontrol, for example, are often exquisitely sensitive to environmental stress, and it is important to dissect with each individual patient what unique environmental situations are known to be stressful. Often these situations may be interpersonal ones, the identification of which can help to avert crises. It is this principle that lies behind the "chain analysis" concept in DBT (Linehan 1993), where careful and detailed analysis of a chain of events leading up to a parasuicidal episode is used to help the patient learn alternative ways to deal with stress.

Clinical Case

The patient, Ms. I, was a 27-year-old single woman referred for treatment because of severe distress she was experiencing in relationships with men. Recent involvement with one man had led to a state of intense jealousy, frequent somatic manifestations of anxiety, and emotional lability. The combination of these circumstances with her characteristic high level of suspiciousness led to a chronically dysphoric mood and a state of brooding and illogical apprehensiveness.

The patient's first noticeable difficulties occurred during her mid-teens when, although she had an aversion to drug or alcohol use, she tried smoking marijuana, forgot her name, and became frightened. Shortly thereafter, while watching television and using no substances, she experienced an episode of depersonalization and derealization. She saw a psychiatrist intermittently for several years thereafter. After college graduation she worked for temporary employment agencies, preferring to be able to leave a work environment immediately if she chose to do so; she felt no clarity about career goals. After the death of her domineering father, she felt "free" to attend graduate school and obtained a professional degree, although she described significant interpersonal turbulence during these years, alternating between sexual promiscuity and periods of isolation. After graduation she returned to temporary work, unable to tolerate the tension-filled responsibility of a future-oriented career direction.

The patient's diagnoses were no disorder on Axis I; schizotypal and borderline personality disorders on Axis II. Her BPD was seen as the hysteroid/dysphoric variety, or Type 1 (affective) in the five-type scheme enumerated above. Weekly psychotherapy was initiated and the patient was given a monoamine oxidase inhibitor (MAOI), which at the time (before availability of selective serotonin reuptake inhibitors [SSRIs]) was recommended for her type of rejection-sensitive hysteroid dysphoria. The patient's highly reactive affectivity (anxiety, depressed moods, near-paranoid fears of male authority figures) remitted remarkably, and the patient became less anxious in therapy itself and able to develop a long-term romantic relationship with a man. However, as the relationship developed, the patient, convinced that all men were incapable of being faithful, became increasingly jealous. She was obsessed with pleasing her boyfriend for fear that he would abandon her, while at the same time feeling tyrannized to the point of suffocation by the rela-

tionship. Unable to leave, she forced him to reject her and experienced tremendous relief.

After a period of calm, the patient became worried that she was abnormal since she had no husband, yet the thought of a new relationship terrified her. She had heard of Prozac and asked to try it; after some discussion, it was agreed to phase out the MAOI and, after an appropriate interval, begin fluoxetine. The patient hoped that the new medication would do a better job of reducing her anxiety and dysphoria. Within weeks, though, she became quite frightened, explaining that she felt nothing on the fluoxetine—just flatness, as if she had lost her identity and now had no way to recognize herself. The fluoxetine was discontinued and the MAOI reinstated, which stabilized her affect. The idea of intimate relationships still filled her with dread, and the therapeutic work consisted of helping her come to terms with the possibility of never marrying, as an acceptable life choice that might be necessary for her emotional health.

This case illustrates stabilizing combined treatment in a patient with BPD who needed ongoing, long-term therapy. In this patient with coexisting schizotypal and borderline personality disorders, the therapeutic work made it possible to identify several uniquely stressful circumstances that regularly led to recurrence of symptoms, such as intimate relationships. One key therapeutic task was to help the patient identify these circumstances and come to terms with them, even if only by avoiding them. In addition, this case illustrates the usefulness of a little-used class of medications, the MAOIs, in selected patients with BPD. Although the MAOI was initiated in this case before the availability of SSRIs, a later trial of an SSRI was unsuccessful. Periodic drug-free intervals were tried with this patient, but they always led to markedly increased symptomatology, so that long-term MAOI maintenance proved necessary.

Step 7: Flexibility

Flexibility is essential in working with borderline patients. Patients with BPD present multiple challenges, and effective therapists will use different approaches with different borderline patients. Any individual patient is likely to have many fluctua-

tions in mood, motivation for treatment, receptivity to the development of a therapeutic alliance, and environmental stress. Therapists are wise to expect change and be sensitive to it. Indeed, it is at times of change and tension in the treatment relationship that central issues come to light and therefore may be interpretable. Gabbard (2000b) described a continuum, shown in Figure 3–2, along which the flexible therapist moves both within individual sessions and over time in working with a patient.

This quality of flexibility is also important for therapists when using a cognitive-behavioral approach. For example, cognitive-behavioral therapy for BPD can emphasize the reduction or elimination of dichotomous thinking (Beck and Freeman 1990), the improvement of skills for controlling emotional and self-injurious behavior (Linehan 1993), changing maladaptive beliefs and assumptions (Young 1990), or the establishment of a clearer sense of identity (Millon 1981).

Gunderson (2001) described five therapeutic functions inherent in the treatment of patients with BPD (i.e., containment, support, structure, involvement, and validation), which, if flexibly and appropriately used, can serve as conceptual and practical guides. Validation, for example, can derive from knowledge of a patient's life experiences, such as a history of trauma. This information can help the therapist empathically convey understanding to the patient of the historical validity of the patient's interpersonal mistrust. At the same time, the therapist's task includes guiding the patient to take responsibility for his or her behavior in the here and now. At any given point in treatment, the balance between validation and compassionate admonition will vary.

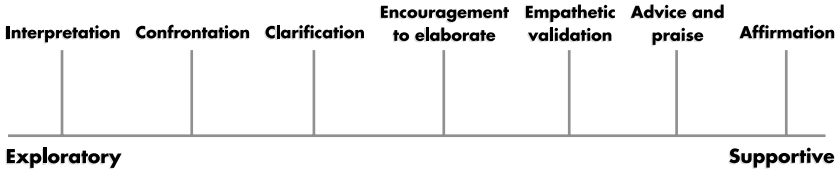

Figure 3–2. An exploratory–supportive continuum of interventions.
Source. Adapted from Gabbard 2000b.

Summary and Conclusions

Integrated treatment planning for patients with BPD involves a comprehensive understanding of the heterogeneous nature of borderline pathology, along with the use of the latest research findings and the clinical recommendations of experts. Great progress has been made in the last decade in recognizing the widespread prevalence of these patients in treatment populations; the high personal, family, and social cost and disability of the disorder; and the effectiveness of new treatment approaches. Practice guidelines for BPD are now a solidly based reality, and an optimistic outlook is beginning to emerge.

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Chapter 4

Integrated Treatment of Alcohol, Tobacco, and Other Drug Addictions

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Introduction

Psychosocial interventions remain the cornerstone of addiction treatment. However, progress in neuroscience and pharmacology has produced several effective medications for use in treating substance use disorders, and the promise of more to come. Resistance among substance abuse counselors to the use of medications, based historically on concerns about "replacing one drug with another," is slowly dissolving. Regarding integration of divergent treatment approaches, the addiction treatment field is today where the mental health treatment field was 25 years ago. At that time mental health care providers often had strong positive or negative opinions about the use of medications but few had given serious thought to the judicious blending of pharmacological and psychosocial approaches. Today, blending medications and therapy in the treatment of mental illness is the norm and has considerable support in the research literature.

This chapter describes the important roles of both medications and psychotherapy in addiction treatment and the possible added benefits of integrated treatment. First we discuss the goals of psychotherapy in the context of medication management, then

specific psychosocial and medication interventions, and finally the empirical literature on the effectiveness of combined treatment of specific substance use disorders.

Successful treatment of substance use disorders may involve the use of multiple specific interventions which may vary over time for any individual patient and which may involve more than one clinician. In providing combined treatment, psychiatrists may be working in a collaborative treatment effort within an addiction treatment program or with a nonmedical therapist who provides the psychotherapy. Collaborative treatment integrates medication and psychotherapy approaches for the patient; however, the involvement of multiple treatment providers requires clear communication within the therapeutic triangle and mutual respect for providers and treatment approaches (Riba and Balon 1999). The collaborative team approach can have advantages and disadvantages at different stages of recovery, but there have been few studies of collaborative treatment within the addiction field.

The American Psychiatric Association's Practice Guideline for Treatment of Patients with Substance Use Disorders (American Psychiatric Association 1995) is an excellent resource on the specific psychosocial and pharmacological treatments for substance use disorders. In addition, it describes the crucial psychiatric management tasks for the psychiatrist providing integrated treatment for substance use disorders (see Table 4–1).

Table 4–1. APA guidelines for psychiatric management of substance use disorders

Establishing and maintaining a therapeutic alliance
Monitoring the patient's clinical status
Managing intoxication and withdrawal states
Developing and facilitating adherence to a treatment plan
Preventing relapse, providing education about substance use disorders
Reducing the morbidity and sequelae of substance use disorders
Diagnosing and treating associated psychiatric disorders

Source. Adapted from American Psychiatric Association 1995.

Goals of Psychotherapy for Substance Use Disorders

There are general and specific goals of psychotherapy in treating substance use disorders. The specific goals vary according to approach. However, the therapeutic alliance is the foundation upon which all interventions rest. Creating a safe, accepting environment where the patient can speak freely, without fear of reprisals, promotes a positive therapeutic alliance. The experience of an alliance with an empathic and nonjudgmental therapist can provide a corrective emotional experience which contrasts to earlier, formative experiences in invalidating, judgmental, and distrustful relationships. However, psychotherapy in the early phases of addiction treatment must balance the development of a therapeutic alliance with the setting of appropriate limits on self-destructive behaviors, manipulative interactions with staff, and inappropriate medication-seeking. Goals for psychotherapy include the following:

- *Help the patient to resolve ambivalence and enhance internal motivation.* Few patients enter treatment with an unequivocal and unshakable resolve to achieve and maintain abstinence. Most harbor considerable ambivalence about giving up a lifestyle that, despite severe negative consequences, is often marked by excitement, euphoria, escape, and an intense though superficial kind of social bonding. Others are convinced of the need to stop, but lack the self-efficacy or skills to do so. Inclusion of a significant other in treatment can be essential to engagement in treatment, and has been shown to reduce treatment dropout (Stanton and Shadish 1997).
- *Provide psychoeducation about the natural history of addiction and of the recovery process for individuals and family members.* Education can sometimes help increase motivation to change, especially when given in the form of specific and individually tailored feedback (Miller et al. 1995).
- *Teach coping skills and relapse prevention strategies.* Such strategies include identifying high risk situations, recognizing and coping with cues for cravings, practicing drug refusal skills,

and preventing an initial lapse from developing into a full-blown relapse (Marlatt and Gordon 1985).

- *Help the patient identify alternative sources of positive and negative reinforcement.* One hallmark of substance dependence is a narrowing of the behavioral repertoire. As compulsive use insinuates itself into every corner of the addict's life, previously valued activities and relationships are abandoned. For many addicted patients, substance use and the lifestyle associated with substance use have become their only sources of pleasure, relief, or excitement. Filling the void left by achieving abstinence and leaving behind the people, places, and activities associated with the addicted lifestyle is a vital aspect of recovery.
- *Help the patient identify and manage difficult emotions.* The self-medication hypothesis suggests that substance abuse is a strategy for managing difficult emotions (Khantzian 1985). Also, empirical research has repeatedly demonstrated difficulties with affect management and a high incidence of anxiety, depressive, and borderline personality disorders in substance-abusing populations (Regier et al. 1990). Marlatt and Gordon (1985) found dysphoric mood to be the most commonly cited precipitant for relapse. For all these reasons, psychosocial treatments that include interventions designed to enhance the ability to tolerate and manage painful affects are crucial to effective integrated treatment.
- *Help the patient cope with guilt and shame.* Empirical research has found that recovering addicts often harbor high levels of shame and maladaptive guilt (O'Connor et al. 1994; Meehan et al. 1996). Maladaptive guilt (survivor guilt, separation guilt, omnipotent responsibility guilt, and self-hate guilt) inhibits the pursuit of wellness and fulfillment and thus of recovery. We have found O'Connor and Weiss's (1993) adaptation of control master theory for addiction—which encourages the therapist to identify and challenge the underlying pathogenic beliefs which fuel maladaptive guilt—to be a helpful strategy with addicts as well as those with other psychiatric disorders. Addiction treatment that is aggressively confrontational may reinforce feelings of guilt and shame (Meehan et al. 1996; Miller and Rollnick 1991; O'Connor et al. 1994).

- *Facilitate engagement in a 12-step program and guide the patient through recovery.* A working knowledge of the 12-step process and of recovery language is important for both patient and clinician. Knowledge of the particular 12-step program's and the recovery community's language and values builds bridges between therapist and patient and enhances therapist credibility by facilitating the patient's engagement in the program.
- *Increase awareness and development of spirituality in recovery.* The 12-step program often encourages an increased sense of spirituality and healthier connections to others. Forgiveness, atonement, spirituality, and dealing with shame and guilt are all issues that can be addressed through psychotherapy.
- *Improve compliance with medication and other components of treatment.* The patient's attitude toward taking medications should be reviewed, including the meaning of taking medications and beliefs and expectations about the role of medications. An initially reluctant patient may relapse and later be willing to consider adding a medication. In many instances, most notably with disulfiram and naltrexone, the involvement of a concerned family member can dramatically improve compliance with medication. Significant others can be enlisted in medication treatment by having them provide positive feedback and appreciation, active monitoring, and encouragement. They can also be a powerful source of support during early phases of detoxification or during the discomfort associated with initiating opiate replacement therapies. We have found that medication compliance in treatment of a co-occurring psychiatric disorder can improve when patients are provided with a pamphlet written by physician members of Alcoholics Anonymous (AA), *The AA Member—Medications and Other Drugs* (Alcoholics Anonymous World Services 1984).
- *Address long-standing self-defeating behaviors.* Several authors (e.g., Larsen 1985) distinguish two phases of addiction recovery. During the initial phase, withdrawal symptoms are treated and strategies for maintaining abstinence are taught. During the second phase (which usually begins after 6 months to 1 year of abstinence), patients are encouraged to focus on changing self-defeating learned behaviors and on mending re-

lationships. In the second phase they may be more willing and able to participate in psychodynamically oriented psychotherapy (Group for the Advancement of Psychiatry 1998; Kaufman 1995; Khantzian et al. 1990).

- *Help the patient improve interpersonal functioning and enhance social supports.* Addicts frequently enter treatment having left a wide swath of destruction in their wake. Family and social relationships have often been damaged or destroyed, with an increasing reliance on social networks composed largely of substance-abusing cohorts. Effective psychosocial treatments should include interpersonal skills building, couple and relationship therapy and involvement of family members or significant others in the process of engaging patients in treatment (Stanton and Shadish 1997).

Clinical Case

Ms. J, a 50-year-old woman who had been married for 30 years and had a long history of alcohol dependence, presented to treatment after a relapse. She had had multiple treatment experiences in the past, most of which consisted of inpatient substance-abuse detoxification and rehabilitation with follow-up consisting of attending AA plus some brief periods of individual supportive outpatient therapy. She did not maintain abstinence for long periods and was quick to rationalize her returning to drinking by attributing it to her marital problems. Her husband had not been involved in the treatment process. In the initial evaluation it was clear that the marriage was in serious jeopardy and that the husband's threats of divorce and of getting custody of the children had motivated her to go to treatment. The husband revealed that he would take days off work to drive for his wife, fearing that she would drive while intoxicated, and that he had developed a pattern of covering up for her periods of intoxication by canceling activities for himself or the children.

The therapist chose to provide a blend of motivational enhancement therapy, relapse prevention, and 12-step facilitation for the identified patient (after detoxification), with the addition of couples treatment including education, Antabuse (disulfiram) compliance monitoring, and problem solving on marital issues. In addition, the husband was referred for individual therapy to address long-standing patterns in the rela-

tionship. This plan allowed a more systems-type approach to the problem rather than looking only at the identified patient as the problem.

Specific Psychotherapies for Substance Use Disorders

Specific psychotherapy approaches have been developed for treating addictions and have been demonstrated to improve treatment outcomes (American Psychiatric Association 1995; Crits-Cristoph et al. 1999; National Institute on Drug Abuse 1999; Project MATCH Research Group 1997). Each psychotherapy approach has a unique theoretical perspective on the etiology and treatment of addiction and is designed to address specific aspects of addiction and its consequences. In clinical practice these approaches are often blended by the skilled therapist. Psychotherapy approaches can also be tailored to the patient's substance abuse problem, including phase of recovery and motivational level. The term *psychotherapy* is rather inclusive and can take on different connotations depending on the clinician's theoretical orientation. A list of specific psychotherapies developed for the treatment of substance use disorders is provided in Table 4–2. These therapies can be integrated or administered concurrently, and most have been described in treatment manuals. We briefly describe three of the more commonly used approaches: 12-step facilitation, motivational enhancement therapy, and relapse prevention. The National Council on Alcohol and Drug Information (NCADI, at 1–800-SAY-NOTO or www.health.org) can be contacted to obtain free training manuals on these three therapy approaches and others listed in Table 4–2. The NCADI is an outstanding resource for patient education, staff training, and research monographs and materials.

- *Twelve-step facilitation* (TSF) is not synonymous with membership in AA. In TSF, the therapist helps the patient understand addiction as a chronic disease and educates the patient about the basic philosophy of AA and the Twelve Steps, including the important role of spirituality in promoting recovery. The

Table 4–2. Core psychotherapies in treating substance use disorders

Motivational enhancement therapy (MET)
Cognitive-behavioral therapy/relapse prevention (CBT)
Twelve-step facilitation (TSF)
Supportive expressive therapy (SE)
Contingency management
Community reinforcement approach
Couples and family therapy

therapist focuses directly on helping the patient achieve abstinence and guides the patient stepwise through the recovery process. Patients are strongly encouraged to attend 12-step meetings (Nowinski et al. 1995).

Psychiatrists whose patients are attending 12-step meetings are encouraged to monitor recovery using the Recovery Status Examination (Chappel 1992). This examination assesses for recent substance use, cravings or thoughts about using substances, and the patient's involvement in 12-step activities. Questions are asked about the number and types of meetings the patient is attending, whether the patient has a sponsor or a home group, and what steps they are working on. Self-help groups can be a vital source of social support and appear to reduce the likelihood of relapse (McCrady and Miller 1993).

- *Motivational enhancement therapy* (MET) aims to help the patient develop a commitment and motivation to change. The therapist adopts a focused but nonconfrontational style while examining the effect of substance use on the patient's life and collaborating with the patient to develop and implement a plan to stop using substances. MET is compatible with Prochaska and DiClemente's stages-of-change model (Prochaska et al. 1992), in which patients are assessed as being in the precontemplation, contemplation, preparation, action, or maintenance stage of change. Those in the *precontemplation* stage are unwilling to consider making changes in their substance use, while those in the *contemplation* stage are experiencing more overt ambivalence about change. The *preparation* stage involves consolidating the patient's commitment to

change and reviewing treatment options, while the *action* and *maintenance* stages involve initiating and maintaining specific change strategies. Generally speaking, patients in the contemplation stage express some willingness to change their substance use within the next 2 to 6 months, whereas those in the preparation stage are willing to make changes in the next month, but not immediately. Patients in the action stage are willing to try making changes at once, and patients in the maintenance stage have changed their behaviors consistently for at least 3 months. However, these time frames should be viewed only as general guidelines for determining a patient's stage of change. Other factors to take into account are nonverbal behaviors and the weights the patient gives to the pros and cons of substance use.

This model emphasizes the importance of tailoring interventions to the patient's motivational level. Interventions aimed at immediate cessation of substance use are often ineffective for patients in the contemplation and precontemplation stages unless there is a powerful external motivator to maintain compliance (legal, employment, or family). Without an external motivator, a confrontational approach is likely to provoke resistance and treatment dropout. A realistic goal for the poorly motivated patient is to simply increase awareness of the impact of the substance use and the possibility of change. Later interventions may involve creating a change plan and discussing feelings of ambivalence, including the patient's perception of the benefits of using substances and of the reasons to stop using substances (Miller et al. 1995).

- *Relapse prevention* is a cognitive-behavioral therapy based on the theory that the maladaptive behavioral patterns of addiction are learned and that the patient can learn to identify and correct these problematic behaviors. The therapist helps the patient achieve and maintain abstinence by helping them to better understand substance use triggers and to improve coping skills and self-efficacy. For example, therapists teach coping and drug-refusal skills to handle the stress of people, places, things, and mood states that are known to trigger relapses (Marlatt and Gordon 1985).

Clinical Case

Mr. K, a 35-year-old attorney with a long history of alcohol, cocaine, and marijuana dependence, presented to treatment after divorce and loss of his job. He had no prior treatment history and tended to minimize his substance use. The therapist, recognizing that the first imperative was to increase Mr. K's motivation to address his addiction, began with MET. Only after Mr. K was more open to the possibility that substance use was a problem for him did the therapist suggest that Mr. K attend AA. To do so earlier likely would have resulted in Mr. K feeling misunderstood and resisting or dropping out of treatment. The therapist's knowledge of AA was essential in assuaging Mr. K's misgivings and reassuring him that he could share his AA experiences with his therapist. For example, describing various types of meetings (open book, speaker, etc.), articulating clearly the mission of AA and its steps and traditions, and providing an up-to-date directory of meetings all afforded Mr. K a greater sense of comfort. It also created a sense of seamlessness between therapy and AA rather than conveying the message that AA was merely auxiliary to treatment.

Timing and Role of Medications for Substance Use Disorders

Used judiciously, medications can improve outcomes among patients with substance use disorders (American Psychiatric Association 1995). Medications can help improve treatment retention and outcome during the acute intoxication, withdrawal, and protracted withdrawal phases. For example, opioid agonist medications can be effective in engaging and retaining the difficult-to-treat heroin addict in opioid maintenance treatment. In addition, medications also serve an important role in the management of co-occurring psychiatric disorders. Table 4–3 lists the medications used in the treatment of alcohol, opioid, nicotine, and cocaine use disorders.

Timing in the use of medication can be complex and depends on several factors. These include the length of current abstinence, target symptoms, the severity and clarity of a co-occurring psychiatric disorder, polysubstance dependence, motivation to change, and patient and physician preference. Medications target

Table 4–3. Medications used in treating substance use disorders

Category of substance use disorder	Indication for medication	Medication
Alcohol use disorders	Detoxification	Benzodiazepines Barbiturates
	Protracted abstinence	Disulfiram (Antabuse) Naltrexone (Revia) Nalmefene[a] Acamprosate[a] Tiapride[a] Odansetron[a]
Opioid use disorders	Detoxification	Methadone Clonidine Clonidine/naltrexone Buprenorphine[a]
	Maintenance	Methadone Levo-α-acetyl-methadone (LAAM) Buprenorphine[a]
	Protracted abstinence	Naltrexone (Trexan) Nalmefene[a]
Nicotine dependence	Detoxification and protracted abstinence	Nicotine replacements (gum, patch, spray, inhaler) Bupropion (Zyban) Nortriptyline[a]
Cocaine use disorders	Protracted abstinence	No FDA-approved medications or studies supporting the use of specific medications; clinicians report using desipramine,[a] amantadine,[a] disulfiram[a]

[a]Not FDA approved for this indication.

a narrow band of symptoms and generally are specific to substance of abuse, in contrast with therapy approaches, which require only minor adaptation for specific substances (Carroll 1997).

Depending on the substance of abuse, protracted withdrawal symptoms can persist during the first year of abstinence. These include cravings, difficulty sleeping, irritability, mood lability,

anxiety, depression, restlessness, problems with concentration, and general malaise (Jaffe et al. 1997). Medications used during this phase may be specific to the substance of abuse or may target more generally the dependence syndrome and the dopamine reward pathway. In these cases, pharmacotherapy typically lasts for 3 to 12 months depending on the severity of protracted withdrawal symptoms, the presence of co-occurring psychiatric problems, patient and physician preference, progress in recovery, and leverage from external sources such as the patient's employer and family and the legal system. During the protracted withdrawal phase, medications (e.g., naltrexone or disulfiram) provide a pharmacological external support that limits a patient's ability to use a substance and increases the likelihood of abstinence, although they may not reduce the actual withdrawal symptoms. The use of multiple medications during the protracted withdrawal period is being evaluated and tested in an effort to improve outcomes (Jorenby et al. 1999).

Using medications during the protracted withdrawal phase requires philosophical open-mindedness on the part of nonmedical addiction treatment clinicians. Psychiatrists working with these clinicians must develop an understanding and respect for how differences in culture, philosophy, training, and experience have resulted in strong differences in attitude, skills, and knowledge related to integrating medications into psychosocial treatments. Some agencies and programs will not use medications during the protracted withdrawal period on principle. Objections often focus on the common misapprehension that all psychiatric medications are mood-altering and can produce dependence, or that patients will be given the wrong message about solving all their problems through medications. In addition, some treatment programs have not had positive physician role models for recovery-oriented prescribing practices or have never seen any patients successfully use medications to achieve recovery.

Co-occurring psychiatric disorders are common among patients in substance abuse treatment and include a wide range of psychiatric problems and disorders (Kessler et al. 1994; Kranzler and Rounsaville 1998; Regier et al. 1990). The most common co-occurring psychiatric problems are mood disorders (10%–30%),

anxiety disorders (20%), posttraumatic symptoms (70%), and personality disorders (57%) (Kranzler and Rounsaville 1998; Rosenthal and Westreich 1999; Substance Abuse and Mental Health Services Administration 1994). Excluding nicotine dependence, about 25%–50% of psychiatric patients have a current substance use disorder (American Psychiatric Association 1995; Helzer and Pryzbeck 1988).

Chronic substance use can lead to depression, anxiety, and even psychotic symptoms such as hallucinations and paranoia. When these symptoms are substance-induced they typically disappear or are substantially reduced in intensity within the first month of abstinence, even without the use of medications (Beeder and Millman 1997). As a result, many in the substance abuse treatment community have assumed in good faith that addiction counseling alone will treat both the addiction and any related psychiatric problems. While this is often the case, a significant percentage of patients have co-occurring psychiatric and substance use disorders and will have poor treatment outcome if not treated with medications or psychotherapy that specifically targets the psychiatric problem (American Psychiatric Association 1995).

Combined Treatment Studies For Opioid, Alcohol, Cocaine, and Alcohol Use Disorders

A selective review of combined treatment studies is provided below. We have organized this review according to the major substances of abuse and the primary medications used in the treatment of the use disorders associated with these substances. (Table 4–3 includes a list of both Food and Drug Administration [FDA]–approved and experimental medications). Most studies have been designed to treat one substance use disorder, and focus solely on the medication being evaluated.

Opioid Dependence

Medications to treat opioid dependence include opioid agonists (methadone, levo-α-acetyl-methadol [LAAM]), partial opioid ag-

onists (buprenorphine, buprenorphine/naloxone), opioid antagonists (naltrexone, nalmefene) and nonopioid detoxification medications (clonidine; Ling and Shoptaw 1997). Integrated treatment studies have evaluated these medications in the context of either methadone maintenance programs or outpatient addiction treatment programs.

In an effort to increase access to and quality of care, European countries have been evaluating methadone and buprenorphine in the primary care physician's or psychiatrist's office (office-based treatment). In October 2000, President Clinton signed the Drug Addiction Treatment Act of 2000, which permits office-based treatment with Schedule III-IV opiate treatment medications. This bill grants physicians the option of providing office-based integrated buprenorphine treatment. This will eventually open the door for psychiatrists and primary care physicians to offer integrated opioid dependence treatment within their current practices, although all the specific ramifications of the legislation are unclear at present, including challenges of implementation and legal liabilities. Buprenorphine plus naloxone is awaiting FDA approval, and appears safer than (i.e., appears to carry less risk of diversion and overdose than) and as efficacious as methadone (Ling et al. 1996). LAAM has been FDA approved since 1993, but has seen only limited usage due to state and local regulatory obstacles, its greater cost compared to methadone, and a failure to effectively market and disseminate information to the treatment community (Rawson and Hasson 1998).

Methadone

Methadone has been the most studied medication in treating substance use disorders and has repeatedly been shown to help addicts extricate themselves from the street life, thereby reducing a host of medical, legal, and social consequences of illegal drug use (Lowinson et al. 1997). In spite of the clear-cut efficacy of methadone maintenance in helping patients with heroin dependence, many addiction clinicians do not support the use of a medication that causes physical dependence. In the United States, methadone for treating opioid dependence can be legally provided only in methadone maintenance programs, which are

highly regulated by government agencies and vary greatly in the amount of psychosocial or psychiatric treatment they provide.

It is beyond the scope of this chapter to review in detail the vast literature documenting the importance of combining psychotherapy with methadone maintenance, but two studies warrant special mention. In a landmark study, Woody et al. (1983) evaluated the benefit of psychotherapy added to standard drug counseling in the course of methadone maintenance treatment. Patients were randomly assigned to receive either drug counseling alone or drug counseling plus supportive-expressive psychotherapy (SE) or cognitive-behavioral therapy (CBT). Patients receiving either psychotherapy fared better on a variety of measures, including reduction in drug use, improvement in health and personal functioning, and reduction in crime, than those receiving counseling alone. Benefits were especially pronounced among those with more severe disorders and included requirement of fewer ancillary antidepressant medications (O'Brien et al. 1995). In a second study, McLellan et al. (1993) demonstrated the general importance of access to psychiatric services in the context of methadone maintenance. Patients were randomly assigned to receive minimal contact (methadone only), standard treatment (methadone plus weekly counseling sessions), or enhanced treatment (methadone, weekly counseling, employment counseling, family therapy sessions, and access to psychiatric services). Results showed a dose-response relationship between services received and a wide variety of outcome measures. In addition, 69% of the minimal contact patients were dropped from the study for providing eight consecutive positive urine screens.

Other interventions have focused on the use of behavioral treatments to reduce substance use while the patient is receiving methadone maintenance treatment. *Contingency contracting* is a popular method involving the use of tangible reinforcement or punishment. Stitzer et al. (1992) used take-home methadone as a positive reinforcer for 2 consecutive weeks of drug-free urine screens. Four times as many of those in the contingent group had at least 4 consecutive weeks of drug-free screens than those in the noncontingent group (32% vs. 8%). Milby et al. (1978) reported similar results, suggesting that this is a powerful intervention for

methadone-maintained addicts. Take-home methadone doses have also been used to reduce the use of nonopiate drugs, with generally positive results (Iguchi et al. 1988; Stitzer et al. 1992), although Magura et al. (1988) found that these results were transient and observed only in non–cocaine-abusing methadone patients. Stitzer et al. (1986) found that the level of methadone dose could be used as a reinforcer for drug-free urines. Kidorf et al. (1997) suggested a similar approach to engaging drug-free significant others in treatment. Procedures involving the contingent manipulation of methadone dose levels have practical and ethical implications, however. Many feel that it is questionable to refuse to provide an optimal methadone dose when research has shown a clear relationship between adequate dose and abstinence and between inadequate dose and treatment dropout and continued drug use (O'Brien et al. 1995).

Studies have consistently demonstrated that the provision of methadone with ancillary psychosocial treatment improves outcomes when compared with methadone provided without psychosocial treatment (McClellan et al. 1993). However, several recent studies suggest that intensive psychosocial services, such as partial hospitalization programs, may be neither more effective nor more cost-effective with methadone maintenance programs than weekly counseling during the first 6 months of treatment (Avants et al. 1999; Rounsaville and Kosten 2000).

Based on the empirical research, we and others (e.g., O'Brien et al. 1995; Rounsaville and Kleber 1985) recommend several practical strategies for integrating psychosocial treatment into methadone maintenance. First, an effective dose of methadone (usually at least 70 mg) remains the cornerstone of treatment, with inadequate doses repeatedly shown to lead to treatment dropout and resumed drug use (Ball and Ross 1991; O'Brien et al. 1995). Second, offering psychotherapy as an integral part of the clinic, rather than as an auxiliary service, is important to treatment outcome and retention. Ideally, psychosocial service providers are fully integrated into the methadone program. At the very least it is crucial that the patient maintain frequent contact with program counselors. This helps to convey to the patient that psychosocial treatment is an integral rather than a superfluous

part of their overall treatment plan. Third, it is vital that those with severe psychiatric disorders be identified early in the course of treatment and offered bona fide dual diagnosis treatment that targets both drug use and psychiatric symptoms.

Naltrexone

Naltrexone is an opiate antagonist that has been FDA approved for use in the treatment of both opioid dependence and alcohol dependence. (Naltrexone is marketed as Trexan for opioid dependence and as Revia for alcohol dependence). In treating opioid dependence, naltrexone has the advantage of being an antagonist medication with a relatively benign side-effect profile, and yet has been used with no more than 1%–3% of treated opiate addicts (Rounsaville 1995). Medication compliance is critical to positive outcomes; research is currently underway to study a depot formulation of naltrexone that may circumvent the issue of compliance and may be a more effective medication option with psychosocial treatments.

Naltrexone's limited use and poor compliance record may be due to the fact that naltrexone has 1) no agonist properties to prevent withdrawal symptoms; 2) a required opioid detoxification phase prior to induction; 3) no physical dependence to maintain addicts in treatment; and 4) a tendency to produce protracted withdrawal (Rounsaville 1995). However, one recent review concluded that combining naltrexone and psychosocial treatment is demonstrably more effective than either alone, and that integrating psychosocial treatment with naltrexone treatment is particularly important given the absence of any reinforcing pharmacological effect (Tucker and Ritter 2000).

Resnick et al. (1981) found that either weekly individual counseling or low-intensity case management increased the likelihood of completing the detoxification and induction phases of treatment among street addicts, except among those who had been on methadone prior to detoxification.

Callahan (1980) reported that contingency contracting and behavioral therapy more than doubled the probability of patients completing 6 weeks of naltrexone treatment, although, because of a small study sample, these results did not achieve statistical

significance. Similarly, Meyer et al. (1976) found that patients paid to consume naltrexone were three times more likely to remain in treatment for 1 month than unpaid patients, a statistically significant difference. Anton et al. (1981), in a nonrandomized trial, found a strikingly low dropout rate (8%) after 1 month among patients receiving family therapy.

Alcohol Use Disorders

Medications used in the treatment of alcohol use disorders include disulfiram, naltrexone, nalmefene, acamprosate, tiapride, and odansetron. Currently, only naltrexone and disulfiram are FDA approved. Most combined treatment studies for alcohol use disorders have focused on evaluating ways to improve medication compliance rather than on comparing different psychotherapy approaches.

Effectiveness of Psychotherapy

Project MATCH (Matching Alcoholism Treatment to Client Heterogeneity) did not include the study of medications, but is noteworthy as the largest study of psychotherapy in the treatment of alcohol dependence (Project MATCH Research Group 1997). This multisite study, supported by the National Institute on Alcohol Abuse and Alcoholism (NIAAA), compared the outcomes of 1,726 patients randomly assigned to one of three manual-based psychotherapy approaches: CBT, TSF, and MET. CBT and TSF were administered in weekly sessions for 12 weeks, and MET was administered in four sessions over 12 weeks. All three approaches were delivered by well-trained, supervised therapists. The main finding was that all three psychotherapy approaches were effective in the treatment of alcohol dependence. At 1-year follow-up there were no differences in outcomes; however, at 3-year follow-up the TSF group was significantly more likely to be abstinent (36%) than was the MET group (27%) or the CBT group (24%). Overall, about 50% of the patients were either abstinent or had significant reductions in alcohol use 1 and 3 years after treatment. Patients with more psychiatric disturbance responded better to CBT than TSF, whereas those high in anger responded better to MET. Those with a social network of

heavy drinkers responded better to TSF at long-term follow-up than to MET or CBT (Project MATCH Research Group 1997).

Disulfiram

The effectiveness of disulfiram (Antabuse) lies in its ability to produce a highly averse reaction in most patients after ingestion of even a small amount of alcohol. It is fully metabolized within 3–4 days and therefore quickly loses its effectiveness if not ingested daily. Medication compliance is the major obstacle to success in disulfiram treatment, and prescribing disulfiram without concurrent psychosocial treatment focusing on compliance has not been shown to be superior to placebo (Allen and Litten 1992).

In a classic study by Fuller et al. (1986), 705 male alcoholics were randomly assigned to receive 1 mg disulfiram (placebo condition), 250 mg disulfiram, or no disulfiram. Patient acceptance was low, with only 38% of eligible patients agreeing to take the medication. No overall effect was found for the therapeutic dose of disulfiram, due to extremely poor compliance (only 20% were rated as having good compliance). However, good compliance was positively correlated with abstinence. Another study of 126 patients attending alcoholism treatment centers, all with histories of relapsing after treatment, found that patients receiving disulfiram had better 6-month outcomes than those receiving placebo on measures of abstinence, drinking days, and health and social problems related to drinking (Chick et al. 1992).

O'Farrell and Bayog (1986) describe an alternative behavioral contracting procedure that does not involve tangible consequences, but rather focuses on eliciting spousal support and appreciation for disulfiram compliance. Couples agree to 1) observed ingestion of disulfiram accompanied by expressions of appreciation by the significant other; 2) deferral of all other discussions about drinking to a time after the ingestion of disulfiram, so as not to unwittingly punish disulfiram compliance; 3) reminders by the significant other to take disulfiram and refill prescriptions; and 4) notification of the treating physician by the significant other if noncompliance was observed. O'Farrell et al. (1993) compared a couples'-group version of this behavioral contracting procedure with a nonspecific interactional couples' group. At the

end of treatment, the disulfiram-contracting group fared significantly better in terms of drinking and marital adjustment, although these differences disappeared by 2-year follow-up. A follow-up study (O'Farrell et al. 1998) demonstrated that the effect of behavioral contracting was enhanced by adding a version of relapse prevention modified for couples, and that spouses of men in the behavioral contracting group had better marital adjustment at 30-month follow-up.

The community reinforcement approach (CRA) is a combined psychotherapy and medication compliance approach that includes disulfiram when treating alcohol-dependent patients (Meyers and Smith 1995; Miller et al. 1999). CRA seeks to change drinking behavior by altering environmental contingencies in the work and social environment so that not drinking is more rewarding than drinking. Disulfiram is one part of a comprehensive intervention that also targets family and community supports. Azrin et al. (1982) evaluated this approach with 43 outpatients at a rural community alcoholism treatment facility. Patients were randomly assigned to 1) treatment as usual plus a prescription for disulfiram without a contract, 2) treatment as usual with disulfiram contracting, and 3) CRA with disulfiram contracting. Disulfiram contracting involved 1) instructing the patient and a significant other in the role and proper use of disulfiram, 2) encouraging the patient to involve a significant other in monitoring, 3) linking administration of disulfiram with daily routines, 4) active monitoring of disulfiram administration by both the spouse and the treating professional, and 5) referral to a physician supportive of disulfiram treatment. Results showed that by 6-month follow-up the no-contract group had almost unanimously abandoned disulfiram, whereas both disulfiram-contracting groups had achieved compliance rates of approximately 90%. The emphasis on mobilizing multiple social supports seemed particularly important to outcome among unmarried patients, who especially fared better with CRA than with traditional forms of treatment. CRA may be especially helpful for patients who do not have a natural support system. This is consistent with later findings suggesting that CRA can be effective with homeless alcoholic men (Smith et al. 1998).

Naltrexone

Naltrexone has been FDA approved for use in the treatment of alcohol dependence as well as in the treatment of opioid dependence. Naltrexone has been shown to be effective in reducing the reinforcing properties of alcohol, thereby reducing the probability of full-blown relapse once drinking has been initiated (West et al. 1999). However, few studies have tested the differential effects of psychosocial therapies when combined with placebo-controlled pharmacotherapy. O'Malley et al. (1992) examined the role of psychosocial treatment with naltrexone treatment. Ninety-seven alcohol-dependent patients were treated for 12 weeks in a double-blind, randomized, placebo-controlled study evaluating naltrexone and manual-guided versions of supportive therapy and coping skills training (relapse prevention). Among those treated with naltrexone, those receiving supportive therapy with a strong emphasis on continuous abstinence were less likely to initiate drinking, whereas those receiving coping skills (relapse prevention) training were less likely to experience a relapse to heavy drinking. A follow-up analysis with the same sample suggested intriguing possibilities for treatment matching. Specifically, patients with lower cognitive functioning fared better in supportive treatment versus coping skills training. The results also suggested that naltrexone attenuated to some degree the negative impact of high levels of craving and lower cognitive functioning. The authors tentatively suggest that the combination of supportive therapy and naltrexone may be optimal for patients with lower cognitive functioning and high craving, a combination generally associated with poor outcome (Jaffe et al. 1996). Anton et al. (1999) reported the results of a double-blind, randomized, placebo-controlled trial comparing CBT with naltrexone to CBT without naltrexone. Retention, completion, and compliance were high in both groups, but the naltrexone group drank less, had fewer relapses, and had more time between relapses over the course of the intervention. Anton and colleagues suggested that CBT, a treatment compatible with a harm-reduction model, may act synergistically with naltrexone to bolster cognitive supports following an initial ingestion of alcohol.

These results are intriguing. It appears that naltrexone's primary therapeutic efficacy lies in its ability to circumvent the loss of control often associated with resumption of drinking, and that it attenuates the frequently observed relationship between strength of craving and treatment outcome. It may therefore be especially appropriate for three groups of patients: 1) those whose cognitive limitations preclude the higher-level cognitive and verbal skills required to absorb a structured relapse prevention approach, 2) those with strong cravings and a pronounced loss of control once drinking is initiated, and 3) those not initially willing to embrace abstinence as a goal.

Cocaine Use Disorders

At present, no medication has been identified that significantly and consistently reduces cocaine use, although promising avenues of research are being explored (Barber and O'Brien 1999). Similar to Project MATCH, the Cocaine Collaborative Study was the largest psychotherapy study of cocaine addiction. Sponsored by the National Institute of Drug Abuse between 1994 and 1996, this 6-month treatment study randomized 487 patients to four psychosocial treatments. All patients received 90 minutes of group drug counseling (GDC; Mercer and Woody 1999) weekly, which is similar to 12-step facilitation but in a group treatment format. Three of the four treatment groups also received some form of individual therapy for 45 minutes twice weekly during the first 3 months and once weekly for the second 3 months. The three individual treatments compared were individual drug counseling (IDC), which resembles the 12-step facilitation approach (Mercer and Woody 1999); supportive-expressive psychodynamic therapy (Luborsky 1984; D. Mark and L. Luborsky, "A Manual for the Use of Supportive-Expressive Psychotherapy in the Treatment of Cocaine Abuse," unpublished manuscript, 1992); and cognitive therapy (Beck et al. 1993). All four of the study treatments significantly reduced cocaine usage by about 70% from baseline to 12-month follow-up. The combination of IDC and GDC was significantly better than the other treatments. Sixty percent of the IDC-plus-GDC group were abstinent at 1-year follow-up compared with 54% for the CT-plus-GDC

group, 53% for the GDC-only group, and 52% for the SE-plus-GDC group (Crits-Cristoph et al. 1999).

Only a handful of studies have examined the interaction between psychosocial and pharmacological treatments. One study (Carroll et al. 1994) randomly assigned 121 cocaine abusers to one of four conditions; clinical management (CM), with or without desipramine, and CBT based on relapse prevention, with or without desipramine. Collapsing across medication conditions, analyses revealed 1) improved outcomes for high-severity cocaine users receiving CBT than CM, 2) better outcomes for low-severity users receiving CM than CBT, and 3) a greater reduction in cocaine use for depressed cocaine users receiving CBT than CM. Collapsing across psychosocial treatment conditions, analyses revealed a greater reduction in depressive symptoms for depressed cocaine users receiving desipramine than placebo.

Carroll et al. (1998) presented results from a randomized clinical trial of five treatments for outpatients with cocaine dependence and comorbid alcohol abuse or dependence. Patients were randomly assigned to one of five treatments: 1) disulfiram in combination with CBT, 2) disulfiram in combination with TSF, 3) disulfiram in combination with CM, 4) CBT alone, and 5) TSF alone. Disulfiram reduced both alcohol and cocaine use and increased treatment retention. These studies suggest interesting potential interaction effects in treating this population. First, using disulfiram for the treatment of a secondary alcohol problem may represent an effective back-door strategy that serves to diminish resistance among patients for whom alcohol is not the primary drug of choice (Carroll et al. 1998). For this reason, monitoring of disulfiram administration may prove less essential in treating primary cocaine abusers. Second, these data are consistent with others (Carroll 1999) that suggest that CBT is particularly effective with depression and with patients with higher levels of impairment.

In the treatment of cocaine dependence and co-occurring psychiatric disorders, the use of medications with blended psychosocial treatments (traditional mental health and addiction treatments) appears to improve outcomes (American Psychiatric Association 1995; Ziedonis and Kosten 1991). We have developed and tested an approach integrating medications and dual recov-

ery therapy (DRT) for patients with schizophrenia. DRT for schizophrenia and addiction integrates modified traditional mental health social skills training with motivational enhancement therapy, relapse prevention, and recovery concepts from TSF. DRT improved treatment outcomes when compared to supportive therapy in a randomized study of 32 patients with schizophrenia and cocaine addiction (Ziedonis and Fisher 1996; Ziedonis and Trudeau 1997).

Nicotine Dependence

Tobacco use is still common in the United States, with about 25% of the population being nicotine dependent. This rate is three times as high among psychiatric and addiction patients (American Psychiatric Association 1996). Some have attributed these findings to various biological, psychological, and social risk factors, including neurobiological vulnerability, increased severity of withdrawal symptoms, poor coping skills, self-medication of attention, mood, and anxiety symptoms, and even the social reinforcements provided in mental health and addiction treatment settings (American Psychiatric Association 1996; Ziedonis and George 1997).

There are currently five medications approved by the FDA for the treatment of nicotine dependence, four of which involve nicotine replacement (delivered via gum, patch, nasal spray, or inhaler) and one of which is bupropion. There are also several other medications with promise. Behavioral therapies, including relapse prevention and motivational enhancement therapy, are the primary psychotherapy interventions. Combined medication and behavioral therapies adapted for use with smokers with schizophrenia (Ziedonis and George 1997), depression (Hall et al. 1998), and substance use disorders (Bobo et al. 1998; Clemmey et al. 1997) suggest ways to modify nicotine dependence treatment for specific patient subtypes. Practice guidelines for nicotine dependence treatment (American Psychiatric Association 1996) recommend integration of nicotine replacement therapies with behavioral and supportive components. Empirical research (Fiore et al. 2000) found that the use of medications doubled the quit rate compared to placebo, and that face-to-face behavioral

therapy doubled the quit rate compared to minimal psychosocial intervention. (Behavioral therapy also increased medication compliance.) Combined treatment (nicotine replacement with behavioral therapy) increased the quit rate by another 50% when compared with either modality given alone and tripled the outcome rate compared to a control group that received a placebo and minimal psychosocial intervention (Fiore et al. 2000). Nicotine dependence treatment guidelines issued by the American Psychiatric Association (1996), the Agency for Health Care Policy Reform (U.S. Department of Health and Human Services 1996), and the U.S. Public Health Service (Fiore et al. 2000) all support combined treatment and are excellent sources of clinical and research information. The interested reader is also referred to recent reviews and meta-analyses by Baille et al. (1994), Fiore et al. (2000), and Hughes (1995).

By contrast with the case for other substances of abuse, support among practitioners for integrated treatment of nicotine dependence is widespread. This is probably due to the development of effective medications and the absence of controversies that have plagued other fields of addiction, particularly with regard to abstinence versus controlled use and medical versus behavioral models of treatment. Unfortunately, few smokers use behavioral therapy because of added cost, lack of local expertise, waiting time for treatment, and preference against group therapy (Fiore et al. 2000). Efforts are being made to make behavioral therapy more acceptable to smokers and to triage smokers to more intensive therapies as needed.

Recommendations and Conclusions

Psychosocial treatment is the cornerstone of addiction treatment, and the development of an effective therapeutic alliance is the foundation of good psychosocial treatment; however, integration of medication with psychosocial treatment appears to further improve treatment outcomes. No single psychotherapeutic approach has been shown to be superior, but well-articulated and competently delivered therapies have repeatedly been shown to improve patient functioning on a wide range of social, psycho-

logical, and substance-related measures. We make the following recommendations:

- Integrated treatment and combined treatment require an understanding of the variability in the natural history of substance use disorders and anticipation of the difficulties and changes which occur during the recovery process. Thus, psychiatrists who practice integrated treatment should have experience in using medications with selected patients to manage acute intoxication and withdrawal, the protracted withdrawal phase, and co-occurring psychiatric and medical disorders, and in maintenance with an agonist medication.
- Medication compliance is an important component of combined and integrated treatments. Spouses and significant others can be powerful sources of external motivation, particularly in the early stages of treatment. It is important that the significant other maintain a positive, reinforcing tone and be empowered to report noncompliance to the treating professional.
- We advise that clinicians be experienced and skilled in at least one of the core individual psychotherapy approaches developed for treating substance use disorders (See Table 4–2), and support 12-step program involvement through 12-step facilitation and the Recovery Status Examination (Chappel 1992).
- In addition to individual psychotherapy, involvement of spouse or family in assessment and treatment can be useful for treatment planning, improving medication and treatment compliance and addressing family and couples issues.
- The assessment of co-occurring psychiatric disorders can be complex and may require the integration of traditional mental health and addiction treatment approaches, including the use of psychiatric medications and, when appropriate, more formal psychotherapy approaches.

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Chapter 5

A Cognitive Therapy Approach to Medication Compliance

Judith S. Beck, Ph.D.

Introduction

Medication compliance varies widely among psychiatric patients. Some sources report that up to 50% or 60% of patients are at least partially noncompliant (e.g., Basco and Rush 1996; Ellison 2000). Many factors influence the degree to which patients comply, including the nature of the therapeutic relationship; side effects of medication; financial resources; a chaotic lifestyle; poor memory; comorbid diagnoses (especially substance abuse); lack of distress; denial of symptoms or problems; interactions with family, friends, and employers; previous treatment experiences; weight gain; discontinuity of care; and misinformation from the media, including the Internet (Basco and Rush 1996; Ellison 2000; Tasman et al. 2000). Some of these factors have a direct impact on compliance, whereas others are mediated by patients' beliefs and thoughts (Basco and Rush 1996; A. T. Beck et al. 1979; Rush 1988; Scott 1995; Scott and Wright 1997; Wright and Schrodt 1989).

How does the clinician identify a patient's particular obstacles to compliance? It is useful to categorize obstacles as practical (e.g., forgetting), psychological (e.g., fear of side effects), or a combination of the two (e.g., reluctance to be assertive with a disapproving family member). Practical difficulties are usually ameliorated by straightforward problem solving; when patients' negative attitudes interfere, cognitive therapy techniques are useful. This chapter focuses on psychological factors underlying

noncompliance, providing a model for understanding this behavior in cognitive terms and strategies to prevent or overcome it.

Cognitive therapy—a time-sensitive, problem-focused, skills-oriented psychotherapy—has been advocated for improving medication compliance (Basco and Rush 1996; A. T. Beck et al. 1979; Goodwin and Jamison 1990; Liberman et al. 1994; Rush 1988; Scott and Wright 1997; Wright and Schrodt 1989). This form of psychotherapy has been demonstrated in two studies (Cochran 1984; Lecompte 1996) to be effective in enhancing patients' adherence to drug therapy.

The Cognitive Model of Noncompliance

According to the cognitive model, individuals' affects and behaviors are influenced by their perceptions of situations. These perceptions arise in the mind as unbidden, spontaneous, or *automatic* thoughts. Automatic thoughts are often dysfunctional or distorted, especially when individuals are distressed. Yet people tend to assume, for the most part, that their perceptions are accurate.

Much of the time people are not even aware of their thoughts; they are much more aware of their moods and behaviors. However, patients can usually be easily taught to identify their automatic thoughts by asking themselves what is going through their minds when they start to feel distressed, or more distressed, or when they recognize that they are behaving dysfunctionally.

Becoming aware of one's thinking is only the first step. In cognitive therapy, patients learn to evaluate the validity and functionality of their thoughts and to respond adaptively to them. Doing so usually leads to improved affect and more-functional behavior (A. T. Beck et al. 1979; J. S. Beck 1995).

Clinical Case

Mr. L was a 30-year-old married construction worker with panic disorder. He believed that the benzodiazepine prescribed by his physician, Dr. A, was likely to have a deleterious effect on him, felt uneasy, and did not take it. When he admitted as much at his next appointment, the physician elicited his automatic thoughts and then intervened. Dr. A provided additional psy-

choeducation, explaining in more detail her rationale for prescribing that particular drug and responding to additional concerns. By the end of the session, Mr. L's perception of the medication had changed; he had a different, more realistic set of automatic thoughts and subsequently took the medicine as prescribed. Table 5–1 illustrates how Mr. L's thinking, before and after his psychiatrist's interventions, influenced his emotional reaction and behavior (compliance).

Most automatic thoughts associated with noncompliance fall into several categories: thoughts about the medication, thoughts about the physician, thoughts about the illness, and thoughts about oneself and others (Table 5–2). Techniques for eliciting and responding to such thoughts are presented later in this chapter.

Many patients, like Mr. L, show improved compliance after their physician provides additional psychoeducation, a direct response to their concerns, or an objective appraisal of their thoughts. A second category of patients usually requires additional strategies because their automatic thoughts (the actual words that pop into their minds) reflect general dysfunctional beliefs about medication, illness, physicians, themselves, and others. These beliefs are deeper-level ideas which patients may or may not have verbalized, even to themselves (J. S. Beck 2000a; Wright and Schrodt 1989). Table 5–3 lists common dysfunctional beliefs related to noncompliance.

Table 5–1. The cognitive model of medication noncompliance, with examples

Situation	Automatic thoughts	Emotion	Behavior
Situation 1: On the evening of his initial evaluation, Mr. L is contemplating taking his first dose of medication.	Dr. A didn't really tell me much about this. Did she really get to know what I need? She was so rushed. What if this actually makes me worse?	Anxious	Doesn't take the medication.
Situation 2: After the next appointment, Mr. L is thinking about taking his medication.	I really should take this. Dr. A says it will probably help. And I don't like feeling like this.	Neutral	Takes the medication.

Table 5–2. Typical automatic thoughts associated with noncompliance

Automatic thoughts about medication
I don't really need it.
I don't want to take it.
It won't work.
It will be addicting.
Automatic thoughts about physicians
She's giving me pills because it's the easiest thing to do.
He thinks he knows everything.
What if he's making a mistake?
Automatic thoughts about illness
Depression is just a weakness.
Nothing can help.
I should be able to get over this without medication.
Automatic thoughts about self and others
I don't deserve to feel better.
I'm not that distressed.
They [friends] will think I'm nuts.
My psychotherapist won't like it.

Table 5–3. Typical beliefs underlying noncompliance

Beliefs about medications
Medications don't work.
Medications are dangerous.
Medications are only for "crazy" people.
Medications should be considered only as a last resort.
Medications should be taken only when someone is feeling bad/sick.
Beliefs about physicians
They push pills to get rid of patients.
They treat everyone the same.
They don't really know what they are doing.
They are only interested in their paychecks.
Beliefs about illness
There is no such thing as mental illness.
It's terrible to need treatment for a mental illness.
Ignoring symptoms will make them go away.
Mental illness can't be cured.

Table 5–3. Typical beliefs underlying noncompliance *(continued)*

Beliefs about the self and others
I should always handle my problems without help.
I could be harmed if I follow doctors' advice.
I am incapable of changing.
People see me as weak.
Doctors are always trying to control me.

Clinical Case

Ms. M, an 18-year-old single mother with major depression and a dissociative disorder, fell in the second category of patients. She had automatic thoughts identical to those of Mr. L, but her thinking was not so easily changed. She had had such thoughts in a number of other medical situations, not only in the current situation with her psychiatrist. Her beliefs included the following: 1) "Medication can be dangerous"; 2) "Doctors prescribe medication because it's easy" (i.e., expedient); and 3) "I can be harmed by doctors." Although these beliefs contained a grain of truth, they did not serve her well in the present situation, and she required additional strategies to improve her compliance. Table 5–4 illustrates how beliefs such as these give rise to specific automatic thoughts and to noncompliant behavior.

The third and most difficult category of patients is that of those who have lifelong negative, global, rigid, dysfunctional core beliefs about themselves, their worlds and experiences, and other people (Table 5–5). These negative core beliefs are quite painful, and individuals develop coping strategies, that is, consistent patterns of behavior across situations and across time, that are invariably dysfunctional in various ways (A.T. Beck et al. 1990; J.S. Beck 1997), as illustrated in the following case examples.

Clinical Case

Mr. N, a 58-year-old attorney, presented with moderate depression, alcohol abuse, and a narcissistic personality disorder. He sought treatment only because his primary care provider had told him he was too special a person to deserve such suffering. Although he frequently acted in a very entitled manner, Mr. N

Table 5–4. Examples of how beliefs lead to noncompliance

Belief	Situation	Automatic thought	Emotion	Behavior
Medication should only be taken as a last resort.	Physician suggests medication to treat patient's anxiety disorder.	I shouldn't take it. I'll try other things instead.	Uncomfortable, then relieved.	Does not get prescription filled.
Having a mental illness is a sign of weakness.	Physician tells patient she has bipolar disorder and should take medication.	She's wrong. I'm all right. I don't need medication. I just have a lot of stress right now. I'm not going to listen to her.	Annoyed	Throws prescription away when she leaves the office.
Doctors are always trying to control you.	Doctor tells patient she really must take medication for her psychotic symptoms.	I don't want to take medication. He thinks he knows me better than I know myself. He can't make me take it.	Irritated	Does not take medication or return for a follow-up visit.

Table 5–5. Examples of negative core beliefs

Self
I am vulnerable.
I am bad.
I am helpless.
I am broken.
I am weak.
I am inferior.
I am a victim.
I am out of control.
Others
Other people are untrustworthy.
Other people will try to control me.
Other people are incompetent.
Other people will harm me.
Other people are uncaring.
Other people will use or manipulate me.
Other people think they are better than me.
Other people have no use for me.
World/experience
Nothing ever works out for me.
The world outside is dangerous.
Bad things always happen to me.
My world is uncontrollable.

had always strongly believed that he was inferior to others. He characteristically displayed certain coping strategies, including demanding special treatment, hypervigilance for slights, continual putting-down of people, and refusal to listen to advice. Before he even met his psychiatrist for the first time, he expected that she would slight him and make him feel inferior. Given his beliefs, he was bound to misinterpret his psychiatrist's behavior and motives. It was not surprising, therefore, that Mr. N refused, at least initially, to take the medication the psychiatrist prescribed (see Figure 5–1).

Clinical Case

Ms. O, a 29-year-old single, unemployed woman, was intermittently suicidal and displayed mood lability, identity disturbance, and other features of borderline personality disorder.

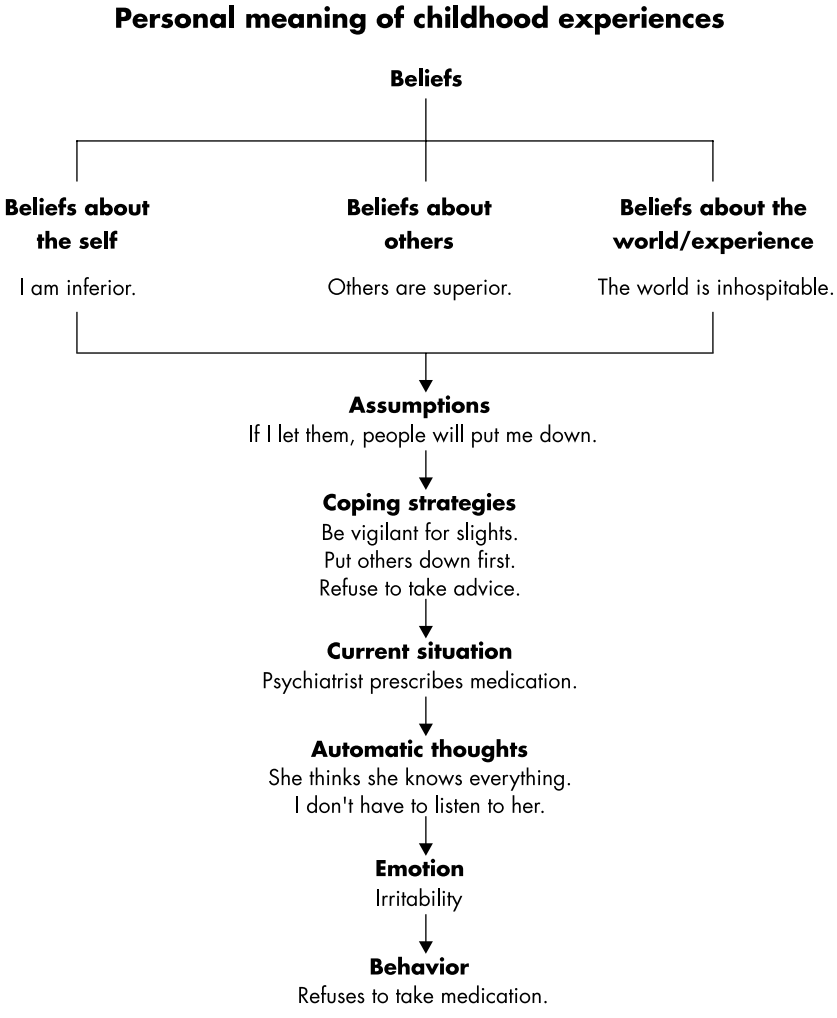

Figure 5–1. Simplified cognitive conceptualization diagram: Mr. N.

She made an appointment with a psychiatrist only because her family had "harassed" her. As a result of her interpretations of and reactions to adverse childhood events, she had developed a number of dysfunctional beliefs. She saw herself as defective, vulnerable, and helpless; others as potentially harmful to her; and her experiences as out of control. Figure 5–2 illustrates how these beliefs gave rise to certain assumptions and behavioral strategies and led, in the current situation, to medication non-compliance.

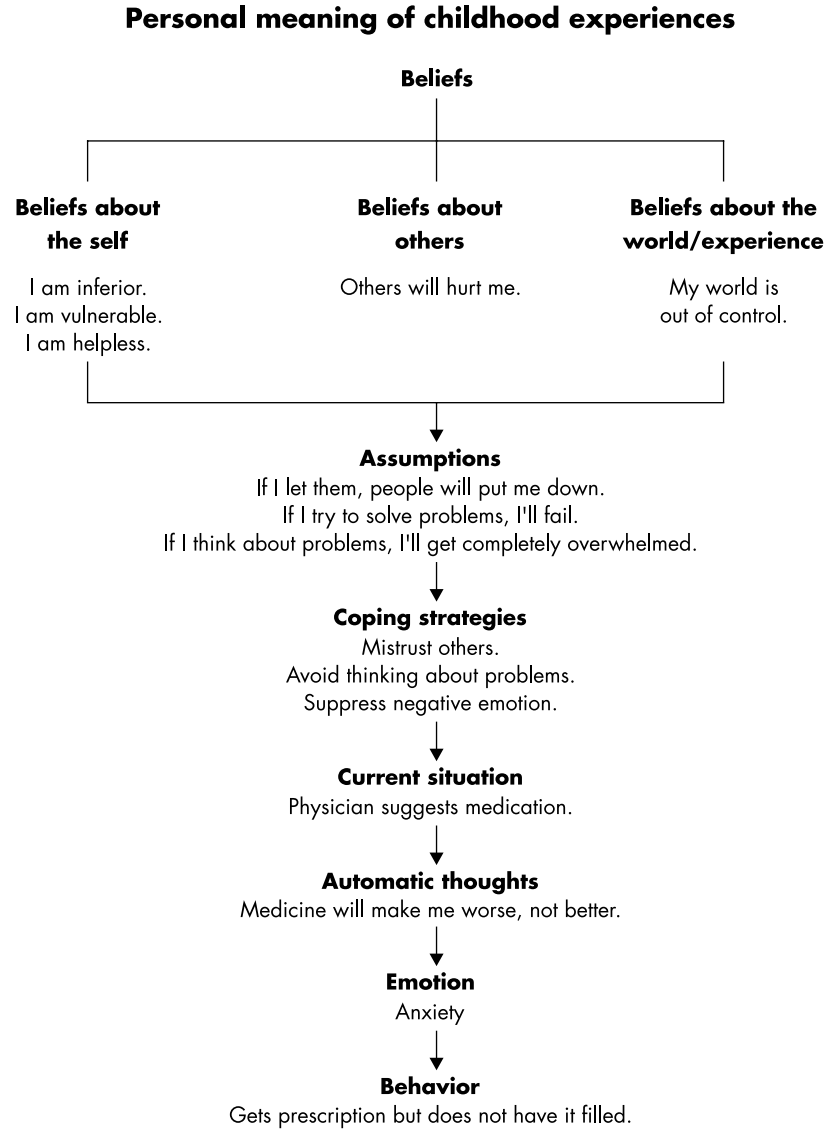

Figure 5–2. Simplified cognitive conceptualization diagram: Ms. O.

Preventing Compliance Problems

Difficulties with adhering to a medication regimen are so prevalent that Rush (1988) advises clinicians to assume that obstacles to compliance always exist and to discuss likely obstacles and so-

lutions before they even arise. Clinicians themselves can prevent many difficulties by using the following strategies:

- Developing a strong therapeutic alliance
- Asking patients for feedback
- Providing sufficient education
- Directly assessing the likelihood of compliance
- Using covert rehearsal

Problems often develop because the clinician has not developed a sound working alliance with the patient. A number of authors have described the importance of the therapeutic relationship and listed critical physician behaviors in promoting adherence (Jibson 2000; Metzl 2000; Rush 1988; Tasman et al. 2000). It is beyond the scope of this chapter to discuss unhelpful clinician verbal and nonverbal behaviors or the beliefs, assumptions, and attitudes that sometimes underlie them; some helpful behaviors are discussed below.

From a cognitive standpoint, clinicians should strive to develop the following positive cognitive mind-set in patients: "My doctor cares about me, understands me, and is competent to help me." Taking sufficient time and exerting sufficient effort to demonstrate caring and interest can foster this idea.

Asking for feedback from patients also strengthens the therapeutic relationship and increases the probability of compliance: for example, "How do you feel about what we talked about today? Was there anything you disagree with or thought I didn't understand? Anything you'd like to make sure we talk about at your next appointment?"

Providing sufficient education also helps prevent noncompliance in many patients (Basco and Rush 1996; Ellison 2000). Educating patients about their disorders, the rationale for medication, and their prognosis if they take medication can enhance adherence. Eliciting and correcting patients' misinformation about medication is also crucial.

Developing a solid therapeutic relationship and providing psychoeducation are necessary but insufficient to gain full compliance from some patients. To discover whether adherence

might be an issue, clinicians can directly assess the likelihood of compliance by asking questions such as the following:

- How likely are you to take [this medication] every day, the way I described, at breakfast and bedtime [or as otherwise prescribed]?
- How likely is it, do you think, that the medication will help?
- Can you think of any problems that could get in the way of taking the medication? For example, paying for it? Getting it from the drug store? Remembering to take it?
- Will your family be okay with your taking it?
- How will you remember to take it?

To uncover additional problems, clinicians can use covert rehearsal. The clinician first asks patients to visualize taking their medication, in detail, then guides them to imagine what difficulties (practical and psychological) might arise. Next, clinician and patient do advanced problem-solving and create adaptive responses to dysfunctional thinking.

Clinical Case

Mr. P, a 23-year-old college student, knew he should take a mood stabilizer and an antidepressant to help him with his mood swings. However, he expressed some ambivalence to his psychiatrist, as follows:

Dr. B [summarizing]: Okay, it sounds pretty certain that you'll get the medicine from the drug store on your way home today, but you think you might not actually end up taking it. Is that right?
Mr. P: Yeah.
Dr. B: Can you imagine now that it's bedtime and you remember you're supposed to be taking the first dose?
Mr. P: [nods]
Dr. B: Where are you?
Mr. P: In the bathroom. Brushing my teeth.
Dr. B: And how are you feeling?
Mr. P: Tired. Worried.
Dr. B: What's going through your mind?
Mr. P: What if it has a bad effect on me? I mean, it could make me zombie out.

Dr. B: Anything else?
Mr. P: Yeah. What if Jim [one of Mr. P's housemates] finds out I'm taking it? He might go around telling everyone.

Together, doctor and patient evaluated Mr. P's first concern and developed an adaptive, more realistic view. Dr. B had the patient practice this adaptive response in imagery.

Dr. B: Okay, now can you imagine having those thoughts, like "What if it has a bad effect on me; what if I zombie out?" again, and answering them back?
Mr. P: [nods]
Dr. B: Now, what about Jim?

Doctor and patient then did straightforward problem solving about where to keep the pills and role-played what Mr. P could say to Jim if his housemate saw him taking medication. Dr. B asked the patient to visualize himself worrying about Jim and to imagine what he would say to Jim and to himself.

Uncovering Noncompliance

Although some patients readily report noncompliance, many are reluctant to do so, thinking that their physician will be disappointed, critical, angry, or rejecting. Asking general questions about compliance is often insufficient. Asking specifically how much of the medication they took and how often they took it may reveal important data about the extent of a patient's adherence.

Clinical Case

Ms. Q was a 33-year-old single woman who worked full-time as a waitress and lived in an apartment with a roommate. Her psychiatrist, Dr. C, diagnosed her with major depression, moderate and recurrent. Following a routine evaluation he prescribed a selective serotonin reuptake inhibitor for her. Ms. Q canceled her first medication check but did keep her next appointment. The psychiatrist checked on Ms. Q's mood through objective scales and self-report and found that she was somewhat more depressed than she had been several weeks earlier. He elicited the extent of her compliance with medication as follows:

Dr. C: I'm sorry you're having such a tough time. Were you able to take the [medication] this month?
Ms. Q: Yeah, I took it.
Dr. C: Were you able to take it every day, at breakfast and bedtime?
Ms. Q [hesitates]: Pretty much.
Dr. C [recognizing the need to get more specific data]: Do you remember which days you took it this week?
Ms. Q: Not really. [thinks] I know I took it yesterday and the day before. I think I forgot to take it over the weekend.
Dr. C: Was this week like the other weeks?
Ms Q: Well, I was better the first couple of weeks. Then . . . I don't know . . . [shrugs her shoulders]

Having collected sufficient data to determine that compliance *was* a problem, Dr. C questioned Ms. Q to uncover the reasons for her nonadherence.

When patients are reluctant to disclose their lack of compliance, normalizing the problem can be beneficial. The psychiatrist might inquire as follows: "You know, some of my patients have trouble taking their medicine. They forget, or don't want to, or have concerns about it. [pause] Do you, also?"

Specifying the Causes of Noncompliance

After determining that noncompliance is present, the physician's next task is to determine whether the roots of noncompliance are practical or psychological in nature or both. Practical problems (e.g., forgetting, confusion about dosing, neglecting to refill prescriptions, an erratic schedule) are often easily solved once the problem is specified. When patients' thoughts and beliefs interfere with adherence, however, cognitive therapy techniques are indicated.

Discovering the Roots of Noncompliance Due to Psychological Reasons

When patients are not fully confident that they will follow through with taking medication as prescribed (or if they return for another appointment and have not been reasonably compli-

ant), and there is no discernible practical problem, it is important to investigate their reluctance through questions such as the following:

- What do you think is the likelihood that the medication will help?
- Why do you think it might *not* help? [if applicable]
- Are you concerned about taking *this* medication or medication in general?
- Why do you think I'm suggesting medication?

- What are you most concerned about? What is your worst fear about taking this medicine?
- How will [your significant others] react? What concerns will they have? *Or:* How did [your significant others] react? What were their concerns?

If patients report full adherence but the clinician suspects some noncompliance, the following questions may be useful: "When this week [or month] was it hardest to take the medication? What was going on?"

Patients are often willing to discuss a problem posed in this way. The clinician can then identify and help patients respond to the automatic thoughts that made taking the medication difficult, without compelling them to reveal their noncompliance.

Behavioral Techniques to Increase Compliance

When patients' reluctance is fairly mild, they often respond to straightforward behavioral techniques. Clinicians can take the following steps:

- Offer check-ins: "Since you're not 100% sure you'll take the medicine faithfully, would you like my office to call you a couple of times this week to see if you're having any problems?"
- Educate family members: "Since your wife is so anti-medication, should we invite her in during our next appointment?"

- Ask the patient to take the medication in the office: "I can see you're still uneasy. How about taking it right now? I have a sample here. Then you can wait in the waiting room until you feel more comfortable."
- Provide a monitoring log: "You know what helps a lot of my patients to be motivated to take the medication? Every time they take it, they put a check mark in the box—under the right time of day and day of the week—and give themselves credit for doing something good."

Cognitive Techniques to Increase Compliance

Patients for whom compliance is a more major issue usually require a combination of cognitive and behavioral techniques (A.T. Beck et al. 1979; J.S. Beck 2000b; Scott and Wright 1997; Wright and Schrodt 1992). It is useful for clinicians to have at their disposal a range of such techniques; a number are described below. Note that Socratic questioning is the major mode of discourse.

Coping Cards

Coping cards are written reminders patients can carry with them to read as needed. They are jointly composed by the patient and physician following a discussion and thus are idiosyncratic to the particular patient. They can be written either by the patient or clinician on index cards, on a page from the clinician's prescription pad, or in a small notebook. The cards contain ideas that patients who were initially reluctant to take medication want to remember after they leave the doctor's office. These ideas are usually self-instructions, responses to predicted automatic thoughts, or both. Ideally, patients read them every time they are supposed to take their medication, at least initially. The cards may also be useful in the future.

Sample cards are provided throughout the rest of the chapter. Because coping cards are effective after a patient has endorsed a new perspective (and when the patient's own words are used), they should be created on the spot and not be preprinted.

Eliciting and Dispelling Objections Due to Misinformation

Patients' concerns often reflect misunderstandings about their illness and the advisability of medication. They have often heard about medication through family and friends, the mass media, and (increasingly) the Internet. They often worry, for example, that they have been misdiagnosed, that their medication may be addictive, that they will experience intolerable side effects, that the medication doesn't work if it doesn't help immediately, or that they will have a bad reaction. Additional education can alleviate their concerns, as illustrated below.

Clinical Case

Ms. R was a middle-aged woman with obsessive-compulsive disorder. She expressed concern to her psychiatrist, Dr. D, about having an adverse reaction to her medication.

Dr. D: So you're worried that you could have a bad reaction?
Ms. R: Yeah.
Dr. D: What make you think so?
Ms. R: Well, my sister-in-law's best friend, Margaret, also has this problem [i.e., obsessive-compulsive disorder] and she said medication made her much worse.
Dr. D: Oh, that's too bad. I hope she kept working with her doctor so he or she could adjust the medicine or try another one. [Dr. D thus offers the notion that doctors can make beneficial changes if the first plan doesn't work]
Ms. R: I don't know.
Dr. D: Because she might have gotten worse if she didn't take the medicine right or had too high a dose [pauses]—or I suppose she could have gotten worse because of extra stress in her life or something like that. [pauses]
Ms. R: [thinks]
Dr. D: Anyway, back to *you*. [The doctor thus attempts to differentiate the patient from Margaret.] What makes you think you'd have the same reaction as Margaret? Do you have the same symptoms with the same severity? Do you think you and Margaret have the same body chemistry?
Ms. R: [thinks] I really don't know.
Dr. D: You know, it's quite possible, in fact it's probable, that you'll fall into the large group of people who get better

when they take this medicine. I don't see anything pointing to your getting worse.

Ms. R: That's good. I sure don't want to feel any worse than I already do.

Dr. D: Me neither. But if you do, we'll just try Plan B.

Ms. R: Okay.

Here the psychiatrist subtly pointed out that the patient didn't have enough information to draw the conclusion that medication would make her worse and alluded to other treatment possibilities that could be explored should the patient have an adverse reaction. They jointly composed the following card:

> *There's no reason to think I'll have a bad reaction.*
> *But if I do, I can just call Dr. D and we'll make a change.*

Examining Advantages and Disadvantages

The clinician can ask patients to list, from their point of view, the potential advantages of taking a particular medication. The clinician or patient can write the list on a coping card. The clinician should suggest additional items for this list which, if endorsed by the patient, are also recorded. Equally important is the elicitation of potential disadvantages and the provision of robust responses to each.

Clinical Case

The following transcript illustrates how Dr. E worked with Jane, a 16-year-old high school student with attention-deficit/hyperactivity disorder (ADHD), to gain her compliance with taking a stimulant commonly prescribed for her disorder. After making the recommendation, Dr. E saw that Jane was distressed. Rather than starting by listing advantages, he elicited her automatic thoughts and started listing the disadvantages she related.

Dr. E: Jane, when I mentioned taking [the medication] you looked upset. What was going through your mind?

Jane [shrugs]: I don't know.
Dr. E: How happy are you about taking it?
Jane: Not very, I guess.
Dr. E [using a different question to elicit her automatic thoughts]: What's the worst part about it?
Jane: I don't know. I just don't want to. I mean, it's artificial. I don't like putting chemicals in my body.
Dr. E [suspecting that there might be other important objections as well] So one disadvantage of taking it is having to put artificial things, chemicals, in your body. [writes this down] What's another disadvantage?
Jane: [shrugs]

Jane was apparently unable or unwilling to express additional disadvantages. Dr. E offered her a multiple choice and normalized her concerns:

Dr. E: Some people see taking medicine as a sign of weakness or that there's something wrong with them.
Jane: Yeah. I guess so. I mean I'm not, like, *that* far gone. I'm not, like, *crazy*.

Dr. E. next provided psychoeducation, pointing out the differences between people with ADHD and the people Jane terms "crazy." She appeared relieved. He then continued to seek out disadvantages to make sure Jane did not have additional unexpressed concerns.

Dr. E: Any other disadvantages to taking it?
Jane: [shrugs]
Dr. E: Do you feel like you're letting yourself be controlled if you take medicine?
Jane: No. Not really.
Dr. E: Does it seem like a burden having to get it and remember to take it and stuff?
Jane: No, not really.
Dr. E: So it's mostly the chemical thing and feeling like taking it would mean you're crazy.
Jane: Yeah. Pretty much.
Dr. E [knowing how sensitive most adolescents are about others' judgments of them]: How bothered would you be if people knew you were taking it?
Jane: A lot.

Dr. E [having the patient identify a specific person so he can help her decatastrophize the potential problem]: Who would be the worst person to find out?
Jane: I'm not sure. My younger brother, maybe. Or Rachel, this girl at school. We used to be friends but now we're enemies.
Dr. E: What could happen with Rachel?
Jane: She could spread rumors about me. Tell people I'm taking medicine because I'm crazy.
Dr. E: Would your good friends believe her?
Jane: No.
Dr. E: Who would care?
Jane: *Her* new friends, I guess. Beth, Hillary, Chris. Those losers.
Dr. E: Do they spread a lot of rumors about people?
Jane: Yeah. All the time.
Dr. E: Do you see what I'm getting at?
Jane: Yeah.
Dr. E: What?
Jane: That they spread rumors about everyone. Everyone knows they make stuff up.
Dr. E: How bad does it sound now, if Rachel found out?
Jane: Pretty bad. [thinks] Not as bad as before.
Dr. E: And your brother?
Jane: Oh, I can make him shut up.
Dr. E: Okay. Now, how much does it bother you to put chemicals into your body?
Jane: Not that much, I guess. I mean, if the medicine could help, I guess it'd be worth it.
Dr. E: That sounds like an advantage—that the medicine could help. Could we talk about other possible advantages now?

Dr. E helped Jane think of a number of advantages by making suggestions in question form (e.g., "Would it be an advantage if . . . ?") and recording her answers (Table 5–6)]. Next he assessed whether further discussion was necessary.

Dr. E: So, what do you want to do? Do you need more time to think about it?
Jane: I guess I'll take it. Till I see you again. I'm not promising anything after that.
Dr. E: Fair enough.

Helping Jane to become aware of the many potential disadvantages, responding to Jane's concerns, and giving her the option of

Table 5–6. Advantages and disadvantages of taking medication: Jane

Advantages	Disadvantages, with reframe
Get more organized. Get more done. Concentrate better. Do school work more easily. Do homework more easily. Get better grades. Stop feeling so dumb. Make me proud of myself. Get to watch more TV.	I'll be putting chemicals in my body, **but** it's not that big a deal and it could help a lot. I'm not that far gone, **but** the medicine can help anyway. This medicine is for people like me, not for people with severe problems. Rachel might find out, **but** it's unlikely she will, and I don't care what her group says anyway. My brother might find out, **but** I know how to shut him up.

not taking the medication all made Jane more amenable to following her doctor's recommendation.

Dr. E: Do you think you might have the urge *not* to take it some time this week?
Jane: I might.
Dr. E: I wonder if it would help to have a card to read to remind you *why* you decided to go for it.
Jane: Okay.

They discussed Jane's reasons, then jointly compose the following card.

> *It's not such a big deal to try this medicine. I'm not crazy, I just have ADHD. I'm not going to let Rachel and her group stop me from doing what I decide is good to do. And there are a whole lot of advantages.*

Conducting "Experiments"

Some patients respond more positively when their doctors acknowledge that *they themselves* don't know precisely what effect the suggested medication will have, and so frame a trial of the medication as an "experiment."

In the following case the clinician shows that she understands that the patient is reluctant, expresses caring, introduces the idea of an experiment, helps the patient recognize he has little to lose, and verifies that the patient does not feel coerced.

Clinical Case

Mr. S, a 72-year-old retired widower, had been suffering from generalized anxiety disorder for nearly a year but was just recently diagnosed. His primary care physician referred him to Dr. F after failing to persuade him to take an anxiolytic. Dr. F made the same recommendation, and she and Mr. S discussed his concerns. However, Dr. F sensed he was not convinced.

Dr. F: Mr. S, I can see that you're still not crazy about the idea of taking medication.
Mr. S: Yeah.
Dr. F: You know, on the one hand, I don't want you to keep suffering this much. On the other hand, there's no guarantee that this medication *will* help. How would you feel about doing an experiment?
Mr. S [looks puzzled]: An experiment? What do you mean?
Dr. F: Well, you've actually done the first part of the experiment already. You have been pretty anxious for almost a year now and *haven't* taken any medication. How are you doing without it?
Mr. S: Pretty bad.
Dr. F: Well, the second part of the experiment would involve your *taking* this medicine—but [judging that the patient may be more likely to commit to a limited, rather than open-ended, time frame.] only for 3 weeks. At the end of that time, we can see what effect—if any—it had on you.
Mr. S: Hmmm.
Dr. F [decatastrophizing]: Well, let me ask you this: what's the worst that could happen if you do this experiment?
Mr. S [thinks]: Have it not work. Get bad side effects, maybe.
Dr. F: In which case, you could decide to stop taking it. How

bad *would* it be if it didn't work? Would you be worse off than if you had never tried it?

Mr. S [slowly]: No . . . I guess not.

Dr. F: What's the *best* that could happen if you took it?

Mr. S: I'd feel better immediately.

Dr. F: And what is the most likely outcome—something in-between?

Mr. S: Well, not the immediate part . . . I don't know.

Dr. F: So are you willing to do an experiment to see?

Mr. S: I guess so.

Dr. F: Are you sure? [Giving the patient the option of retracting can help him fortify his decision.] Do you feel like I just talked you into something against your will?

Mr. S: No, not really. I'll try it. I guess I don't have that much to lose.

Dr. F: Do you think you might get tempted to stop the experiment early?

Mr. S: Yeah, I might.

Dr. F: Wouldn't it be a shame, though, if you stopped the experiment early and never found out, really, if it could have helped? Like this human genome project, have you heard about it? What an incredible waste if the scientists who were doing the experiments to map it thought they couldn't do it and just stopped.

Mr. S: I'm amazed they can do it at all.

Dr. F: Me, too. [pauses] Now, how about you? Can you commit yourself to doing this experiment for the full 3 weeks?

Mr. S: Yeah, I guess so.

Dr. F. then discussed dosages, schedules, and potential side effects. She and Mr. S collaboratively devised a coping card to increase Mr. S's motivation.

> *I might as well do the experiment, even if I'm not sure if I want to. I sure don't want to keep feeling this lousy. What's the big deal anyway? It might not work, but then again it could.*

Eliciting and Responding to Patients' Automatic Thoughts

Patients may feel uneasy about taking medication without being able to specify exactly why they feel this way. It is helpful to elicit their specific thoughts by making one or more of the following inquiries:

- "What just went though your mind when I suggested medication?" or "What went through your mind this week when you thought about taking the medicine?"
- "Were you thinking…?" [Clinician supplies automatic thoughts opposite to the predicted ones] For example, "Were you thinking that you were so happy to take the medicine?"
- "What does it mean to you to have [this illness]? What does it mean about you?
- What does it mean to you to have to take medication? What does it mean about you?

If patients have difficulty identifying their automatic thoughts, clinicians can ask them to remember a specific time when they thought about taking the medication but didn't. Patients can be asked to visualize the scenario in detail (a process similar to covert rehearsal) and focus on their feelings before focusing on what they were thinking; this often prompts memory.

Having elicited patients' automatic thoughts, clinicians can use a number of techniques described in this chapter to help them respond to their thoughts. One important intervention involves questioning patients so they can assess the accuracy and functionality of their thoughts. Table 5–7 contains common Socratic questions directed to this end. Clinical judgment is needed to decide which questions will be most useful with a given patient.

A coping card could contain the most persuasive ideas engendered by these questions. It is also important to ask patients to note their automatic thoughts when they are noncompliant so these thoughts can be addressed during the next appointment.

Table 5–7. Socratic questions to evaluate automatic thoughts

What is the evidence that this thought (e.g., "Medication won't work") is true? What's the evidence on the other side, that this thought is not true, or not completely true?
What is an alternate explanation or a different way of looking at the situation?
What's the worst that could happen? If it did happen, how would I cope? What's the best that could happen? What's the most realistic outcome?
What's the effect of my believing this thought? What could be the effect of changing my thinking?
If _____ (a specific friend, family member, etc.) were in this situation and had this thought, what would I tell him/her?
What should I do?

Source. Adapted from J.S. Beck 1995.

Giving Self-Credit

Patients who have dysfunctional automatic thoughts after they take their medication are less likely to continue taking it. Ensuring that patients give themselves credit, instead of being self-critical, is important.

Clinical Case

Mr. T, a 45-year-old electrician with bipolar disorder, suddenly became noncompliant with his medications. Cognitive interventions seemed to have motivated him to start taking them again. The clinician suspected, however, that Mr. T's resolve was not sufficiently strong to assure full compliance, so she intervened further.

Dr. G: What do you predict you'll think *after* you take the medicine tonight?

Mr. T: That I wished I didn't have to take it. It makes me feel like I'm *really* bad off if I need it. [pauses] You know, I don't like taking *any* medication, not just these.

Dr. G: So when you do take it, it will be important to tell yourself that you really deserve credit for doing something you need to do, even though it really bothers you.

Mr. T: Yeah, I guess so.

Dr. G: It's probably going to be hard to remember to do that. What do you think about having a written reminder [i.e., a coping card]?
Mr. T: Okay.

Dr. G and Mr. T jointly composed the following coping card:

> *There. I took the medicine. It takes a strong person to do something he knows could help but is really opposed to. I do deserve credit for taking it.*

Positive and Negative Imagery

Some patients improve compliance after visualizing in detail the probable long-term consequences of either taking or not taking needed medication.

Clinical Case

Ms. U, a 77-year-old homemaker, was reluctant to take medication for her anxiety disorder.

Dr. H: Ms. U, can you imagine it's 6 months from now? Let's see, that would make it mid-December, right before Christmas. Imagine you haven't taken this medication. How are you feeling? [pause] How are you managing? [pause] What does your day look like? [pause] Try to picture it in your mind. You're still as anxious as you have been this past month. [pause] What happens when you first wake up? Have you slept well?
Ms. U: Probably not. I probably tossed and turned all night.
Dr. H: Do you get out of bed right away? Can you picture it?
Ms. U: Yeah. I get up right away. If it's close to Christmas, I'm even more frantic than usual. I'll probably rush through all the morning stuff so I'll have time to do all the holiday stuff I need to do.
Dr. H: As you're rushing through the morning—getting washed up, getting dressed, making breakfast, I imagine—as you're

rushing, how are you feeling? Excited? [Dr. G is supplying a response opposite to the one he actually predicts.]

Ms. U: Oh, no. Anxious. Very anxious.

Dr. H: And you'll be worried that—?

Ms. U: I won't have enough time, I'll have so much to do. Our children and grandchildren will be coming in a few days. Oh, I couldn't disappoint them. No, I'll probably be beside myself.

Dr. H: So the days leading up to Christmas won't be fun, but rushed.

Ms. U: Yeah, very rushed.

Dr. H: Now I'd like you to imagine that you've been taking this medication for 6 months and it's been working. You feel like you're back to your old self. [pause] What does this scenario look like? [pause] What happens when you wake up? [pause] Have you slept poorly?

Ms. U: No, not if I'm back to my old self. [thinks] Well, maybe not as well as usual if I have a lot on my mind with Christmas coming.

Dr. H: The same as if you hadn't taken any medicine at all?

Ms. U: Oh, no. Much better than that.

Dr. H: Okay, you wake up. What then?

Ms. U: Well, I probably do the same things. I rush through my morning stuff . . .

Dr. H: And what's your mood like, if you're back to your old self?

Ms. U: If I'm back to my old self? Well, I'll still probably be anxious because December is so busy.

Dr. H: How anxious will you be? Will you feel excited, too? Glad that your kids and their families are coming soon?

Ms. U: Yeah. I'll be anxious, but glad, too. Excited.

Dr. H: Are you picturing that?

Ms. U: Yeah.

Dr. H [pauses]: What do you think? Are you inclined or disinclined to take medication?

Ms. U [thinks]: I think I'll take it. Yeah. I really should.

Together, Dr. H and Ms. U composed the following coping card:

> *I really want to feel good this Christmas. I want to be able to enjoy myself. I should really take the medicine because it's likely to help.*

Cognitive Restructuring of Core Beliefs

Because core beliefs, especially those held by patients with personality disorders, can be so negative, global, deep-rooted, rigid, and long-standing, they often require sustained work over a period of time. Many patients with strong beliefs, however, become compliant after developing a trusting relationship with their psychiatrist. Some require a strong cognitive behavioral approach. Other patients, unable to establish such trust, require a specialized approach (A.T. Beck et al. 1990; J. S. Beck 1998; Young 1999).

Summary

Both practical problems and psychological factors are involved with medication noncompliance. Many difficulties can be avoided or ameliorated through problem solving and the development of a strong therapeutic alliance. Asking patients specific questions can help clinicians assess the likelihood of compliance, the actual degree of compliance, and the nature of the obstacles associated with lack of compliance.

When psychological factors are involved, the cognitive model is useful in conceptualizing and remediating noncompliance. Patients bring to treatment their beliefs about medication, physicians, illness, themselves, and other matters. These beliefs influence their interpretations of what their physicians do and say. Interpretations (expressed in patients' minds as automatic thoughts) that are distorted often lead to noncompliant behavior. A variety of cognitive and behavioral techniques however, can significantly improve patients' compliance.

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Chapter 6

The Challenges of Split Treatment

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Clinical Case

Mr. V, a 52-year-old divorced man with a history of panic disorder and intermittent alcohol abuse, was brought in to the Emergency Department after he was noted by neighbors to not be caring for himself. Mr. V was morose after a long-term relationship had ended. He said that he had been in therapy with a social worker but had stopped the sessions about 6 months ago due to financial constraints. Mr. V noted that he received an antidepressant medication from a psychiatrist whom he saw every 3 months but had missed his last appointment. Both the social worker and psychiatrist were called by the emergency staff. The social worker did not carry a beeper and the voice mail said she was away for 2 weeks. The psychiatrist was unaware that Mr. V had stopped his psychotherapy appointments and had lost track of the patient after the missed appointment.

The example above represents split therapy at its worst—poor communication between the clinicians; a patient who gets lost to follow-up; a social worker who doesn't maintain coverage when away; altogether, a system of care that doesn't provide maximum benefit for the patient. While not all of split treatment is bad, there are areas of concern that merit in-depth discussion. This chapter will examine the positive and negative aspects of split treatment, and in conclusion will present some clinically useful ways to optimize this type of care.

Introduction

The term *split treatment* is not universally accepted; the literature employs various terms (see Table 6–1) to denote the practice by which a psychiatrist or other physician provides the psychotropic medications while a nonphysician (e.g., social worker, psychologist, counselor) provides the psychotherapy. Throughout this chapter, the term *split treatment* will be used to denote this type of care.

The last time psychiatric guidelines were organized and published on this practice was in 1980, when the American Psychiatric Association drafted a "'living document to be adapted to local custom and practice" (American Psychiatric Association 1980). This publication attempted to review the roles and responsibilities of psychiatrists in the range of consultative, supervisory, and collaborative relationships with other professionals and nonprofessionals in a wide variety of systems of care. Since that time, no other set of official psychiatric guidelines has been provided on this subject.

An interesting historical aspect is that early split treatment was generally provided by two physicians, a psychiatrist-prescriber and a psychoanalyst-therapist (Fromm-Reichmann 1947). The subsequent growth of split treatment has been due to a number of factors, including the increased penetration of nonphysician therapists into mental health services (Beitman 1983; Goldberg et al. 1991; Pilette 1988) and the expanding role of primary care physicians (PCPs) in treating the majority of patients with emotional problems in the United States (Horgan 1985; Regier et al. 1978; Valenstein 1999). The education and training of nonphysician therapists can vary greatly, as can the psychological bent of the PCP, thus making each split treatment relationship between clinicians highly subjective and individual (Neal and Calarco 1999).

The explosion of safer and cheaper psychotropic medications in all major classes (i.e., antidepressants, antipsychotics, anxiolytics, mood stabilizers) has allowed PCPs and other physicians to have increased comfort in prescribing and therefore in participation in split treatment. In general, the public has become more ed-

Table 6–1. Terms used as synonyms for *split treatment*

Collaborative treatment
Combined treatment
Concurrent care
Divided treatment
Integrated care
Med backup
Medical backup
Medication check
Medication management
Parallel treatment
Shared treatment
Triangular [or triangulated] treatment

ucated about the use and value of psychotropic medication. Books such as the best-seller *Listening to Prozac* by psychiatrist Peter Kramer (1993) have made *antidepressant* a household term. There is widespread advertising of psychotropic medication in the print and media. The Internet has allowed consumers to read about and understand medications, and for many has destigmatized mental illness and the psychotropic medications used for its treatment. Patients are no longer surprised when psychotropic medications are offered as part of the treatment plan, and in fact many have come to expect it.

Cost containment and the emphasis of managed care on multidisciplinary care delivery, especially in the outpatient setting, have also contributed to the increased practice of split therapy. Use of less costly nonmedical therapists rather than more expensive psychiatrists to provide psychotherapy to patients has certainly been a strong driving force in recent years (Kerber 1999). The ensuing role changes for psychiatrists have included moving from *treater* or *provider* toward *evaluator* or *consultant*. Interestingly, recent work has asked whether split treatment is indeed more cost effective as well as clinically efficient than having a single psychiatrist provide both psychopharmacology and psychotherapy (Goldman et al. 1998).

Finally, there has been a growing trend in psychiatric resident training that may be related to the burgeoning of split treatment (Riba et al. 1993). This development relates to a decreased emphasis in psychotherapy training in residency. A recent article by Mischoulon et al. (2000) delineated issues regarding transfer of care of "psychopharmacology patients" to other residents, noting that there has been a shift away from thinking about dynamic issues in such transitions. Residents increasingly are viewing themselves as prescribers of medication rather than as physicians who need to work through the underpinnings of mental illness with their patients (Spitz et al. 1999). The following case reveals such an issue.

Clinical Case

Ms. W, a 28-year-old single mother diagnosed with major depression (recurrent with psychotic features) and borderline personality disorder, had been in psychotherapy with a social worker at the community mental health center for 3 years. Ms. W had been taking both antidepressants and antipsychotic agents and was recently hospitalized after a serious suicide attempt by overdose. An inpatient conference was held to determine whether Ms. W's suicide attempt could have been avoided. The outpatient resident at the community health center was asked to present Ms. W's case and proceeded to discuss what medications she had been on and her medical history. When asked what Ms. W's most recent psychosocial stressors were that could have led to the suicide attempt, he said, "Please ask the social worker. I am Ms. W's psychopharmacologist."

The role of the psychiatry resident—in fact, of all psychiatrists—has become increasingly blurred. The provision of psychotherapy, previously viewed as a necessary skill in the armamentarium of psychiatrists and in the training of residents, has ceased to be essential because of the rise of split treatment. In recognition of these problems, the American Psychiatric Association developed its Commission on Psychotherapy by Psychiatrists, and the Residency Review Committee in Psychiatry of the American Medical Association has promulgated new regulations for training in psychotherapy (effective January 2001). Although these actions will help, the fundamental problems regarding split

treatment and the identity of psychiatrists with regard to psychotherapy remain.

The discussion of split treatment above is meant to provide the reader with a broad sense of the complexity of the issues surrounding this type of care. There are many varieties of professional involved with this system of care; further, split therapy is pervasive in all treatment settings: inpatient, outpatient, community mental health center, private and managed practices, partial programs, and even emergency settings. The following sections will elaborate on the specific positive and negative aspects of split treatment.

Positive Aspects of Split Treatment

When it is practiced well, there are many positive aspects to split treatment (Balon 1999). Discussion of some of these aspects follows.

Patients Have More Time With Clinicians

In split treatment, patients have the opportunity to work with at least two clinicians: one nonmedical therapist for psychotherapy, one physician for psychotropic medication. In this arrangement, patients are generally seen by the therapist for 50-minute sessions and by the psychiatrist for 20- to 30-minute sessions. How frequently these sessions occur is dictated by clinical need, fiscal resources and medical benefits, and clinician availability.

Clinicians' vacations may be easier for some patients to negotiate in split treatment. For example, if vacations can be planned and staggered, it is helpful for some patients to be able to see one clinician when the other one is away. This might avoid crises for patients who feel abandoned or angry during clinicians' vacations, as exemplified by the following case.

Clinical Case

Susan, a 19-year-old college sophomore with anorexia nervosa, was doing summer school work when her pregnant therapist delivered her baby 6 weeks earlier than expected. Arrange-

ments were quickly made for Susan's psychiatrist to see the patient more often and to help deal with her therapist's abrupt departure. Susan had very mixed and conflicted emotions during the period of the therapist's absence. The psychiatrist was able to help Susan negotiate many of the wide-ranging mood states and conflicts that arose during this time. When the therapist returned, a session was held with the patient and both clinicians to help with the transition back to Susan seeing the therapist for psychotherapy.

Because of the greater amount of time spent with clinicians in split therapy, patients may be able to provide more clinically useful information than would be possible with just one clinician. There may be information that the patient feels comfortable sharing with one of the clinicians, not with the other, such as medical issues with the physician. The psychiatrist and therapist should make sure to share such information in order to give the best care possible to the patient (Pilette 1988).

Better Use of Available Resources

Cost-effective use of resources is important for both patients and clinicians. As there is an increased understanding on the part of PCPs and patients regarding the symptoms of mental illness, there are more patients who recognize the need for quality mental health care. While this is good, the system of care must be expandable enough to provide for those who need it. A multidisciplinary combination of care sources optimally allows for a triage system wherein therapists see patients for mild to moderate symptomatology and more severe cases are referred to psychiatrists. Split treatment lends itself very nicely to this type of triage system because all patients who need psychotropic medication have the benefit of seeing both therapists and physicians. This is illustrated in the following case.

Clinical Case

Mr. X, a self-employed construction worker, was hospitalized for an acute myocardial infarction. He was seen by a psychiatrist in the hospital for mild depressive symptoms and felt relieved and helped by this intervention, which included a

prescription for an antidepressant. Upon discharge, Mr. X was referred to a social worker who was part of his health maintenance organization but was also approved to follow up with the hospital psychiatrist every 2 months.

Greater Choice of Clinicians

Split treatment offers the patient a greater opportunity to choose a clinician who resembles the patient in gender, race or ethnicity, religion, or cultural values. Such matching may help avoid some of the difficulties that arise in psychotherapy when clinician and patient belong to different racial and ethnic groups (Foulks and Pena 1995). Additionally, such matching could help enhance the therapeutic alliance for patients who might feel uncomfortable or mistrustful of clinicians of certain backgrounds. Cultural and language barriers have deterred some patients from seeking mental health treatment (Ruiz et al. 1995). Each culture has unique traditions and values which may be misunderstood or misinterpreted by clinicians (Yamamoto et al. 1993). There has been a greater emphasis in psychiatry residency training on raising such cultural issues and providing better teaching and training. There will, however, always be a gap between what some clinicians know about various cultures' values and the relative importance of those values in determining patients' psychological problems and psychosocial stressors. As noted by Balon (1999), such factors may play a critical role in the development and presentation of mental illness and in psychotherapy.

Clinical Case

Ms. Y was a 26-year-old pregnant Japanese woman who accompanied her husband to the United States so that he could study computer engineering. She became quite despondent in the last trimester of her pregnancy, and was not eating or sleeping. Members of her church tried to provide support and reassurance. Ms. Y's shame and guilt over her depression and low self-esteem seemed overwhelming. Her family was quite concerned but refused the obstetrician-gynecologist's referral to a psychiatrist. It was not felt to be culturally appropriate to see a therapist and discuss family problems with someone outside the family system. A social worker of Japanese heritage was

found in the community, and the patient agreed to be seen for a consultation.

Another advantage of having two clinicians is the opportunity to capitalize on the unique talents and skills of both. For a 17-year-old anorexic patient who becomes depressed when her parents divorce, it might be optimal to see a social worker with a specialty in eating disorders and also to see a child and adolescent psychiatrist whose specialty is in the psychopharmacology of mood disorders. In rural areas where there are not enough psychiatrists for the population, it might be especially helpful to balance the psychiatrist's skills with those of a therapist.

Enhanced Professional Support for Clinicians

When split treatment works well, clinicians enjoy a feeling of enhanced collegial support for one another. Split treatment allows for a feeling of mutual caring and for sharing of information that helps clinicians help each other and the patient through crises. Pilette (1988) noted that this was especially true with difficult patients during difficult times. Patients with borderline personality disorder, for example, are notorious for fueling strong countertransferential feelings of anger, fear, and worry in clinicians (Silk 1999). It is therefore quite helpful for clinicians to work together to present the unified message that they can handle the various affective storms presented by certain patients. At the same time, the clinicians can provide a way for each other to diminish burnout with such patients. By sharing the patient and his or her affective storms, split treatment spreads the wealth; the patient with borderline personality disorder has two clinicians to idealize or devalue. When the clinicians can recognize and communicate about this with each other and the patient, it may help to clarify and sometimes even calm the situation.

The idea of split therapy enhancing clinicians' emotional support of one another is especially true in a clinic or community health setting where clinicians see each other often and have time to communicate. Psychiatry residents, in particular, value the teaching and support they get from seasoned, mature social workers and psychologists while providing split treatment (Balon 1999).

In split treatment the therapist has the opportunity to learn more about psychopharmacology and the specific actions and side effects of medications. The physician, with the help of the therapist, has an opportunity to better understand psychodynamic principles. Patients' diagnostic differentials can be discussed between the clinicians, and aspects of personality or medical issues can be deliberated. Psychodynamic principles, transferences, resistances, and defenses are likely to be viewed differently by each clinician. Nevertheless, these differences, if communicated and discussed in a thoughtful manner, can be used in a positive way to better understand and help the patient.

Enhanced Adherence to the Treatment Plan

Patients often have a strong resistance to taking their medication as prescribed. Psychotherapy may either help or hinder medication adherence (Paykel 1995). In split treatment, the therapist can help encourage the patient to stay on the medication while the psychiatrist supports the psychotherapy efforts of the therapist. The patient can ask questions and is provided education from both clinicians. Each clinician can help advocate for the patient and perhaps help and support the patient through difficult stages of both medication adherence and psychotherapy.

The meaning and role of medication and psychotherapy are critically important. Sometimes it is confusing for the patient to know what to value when she or he is getting better. This is exemplified in the following case.

Clinical Case

Mr. Z, a 56-year-old married man, became quite depressed after being laid off from the job he had held for 22 years. He was in counseling with a social worker, who recommended he be evaluated by a psychiatrist for antidepressant and sleep medication. Within 3 weeks of starting the medications, Mr. Z had decreased vegetative symptoms of depression and felt more like his "old self." He told the psychiatrist that he was planning on stopping therapy with the social worker. The psychiatrist strongly urged that Mr. Z continue in therapy and that the combination of medication and psychotherapy would in his case be most helpful. The psychiatrist spoke with the social worker

about this and the social worker also conveyed the importance of care by both professionals.

Negative Aspects of Split Treatment

There are also quite a few negative aspects of split treatment (Goldsmith et al. 1999). For split treatment to work well, there needs to be excellent communication between the patient and clinicians, mutual respect and regard for clinicians' practices, and well-thought-out treatment plans. Split treatment is a complicated practice with many pitfalls and opportunities for problems.

Interdisciplinary Issues

When clinicians know each other and can refer patients to one another for split therapy, they are more comfortable with this system of care (Goldberg et al. 1991; Weiner and Riba 1997). Many times, however, the clinicians in split treatment don't know each other at all. Fueling this unfamiliarity are basic hierarchical issues in medicine that place physicians at the top and add to feelings of inequality and competition between clinicians (Baggs and Schmitt 1988). This inequality may not remain between the clinicians but be displaced onto the patient during the making of treatment decisions. In fact, some patients are sensitive to this problem and unconsciously exploit the competition between clinicians (Kelly 1992). Further, there has recently been increased political tension between psychiatrists and psychologists over the issue of prescribing privileges. Finally, the psychotherapy skills and psychopharmacologic education of social workers and psychologists are highly variable (Neal and Calarco 1999).

It is therefore little wonder that clinicians who don't know each other and who are engaged in split treatment might be wary of one another's strengths and weaknesses. In such circumstances the patient may gain little from the split treatment. The patient may actually be seen more often by *both* clinicians and have unclear treatment goals.

Communication

It is difficult enough for clinicians to keep up with the usual load of paperwork, telephone calls, e-mails, and so on. Yet a major responsibility in split treatment is to communicate with one another. This is rarely done well (Hansen-Grant and Riba 1995), unfortunately, and can lead to misperceptions and misunderstanding between clinicians and patients. Even though patients in split treatment should sign explicit consents allowing conversation to occur between one clinician and the other (Appelbaum 1991), what the limits of such conversations should be and what details may be communicated is often unclear.

Communication issues lead to problems such as not transmitting important information regarding dangerous patient situations; not knowing when the other clinician is going on vacation, and assuming that someone will be in town to take care of the patient; making the patient feel that she or he is the messenger between the clinicians; misunderstanding or misinterpreting psychodynamic issues as medication side effects and vice versa; devaluing either psychotherapy or medication indirectly or directly; not having a well-constructed treatment plan; and so on.

Transference and Countertransference

Busch and Gould (1993) have described some of the negative transference reactions that patients may have when their therapists refer them for medication. Such reactions include feeling that the therapist has given up, rejected the patient, or lost interest; overvaluation of the medication and the "chemical imbalance" that supposedly drives the need for medication; idealization of the physician; devaluation of psychotherapy and of the therapist; loss of confidence in the therapist; resistance to the exploration of painful issues in psychotherapy; and narcissistic injury and assault on the autonomy of the patient. Busch and Gould note the potential countertransferential feelings of the therapist (shame that he or she was not able to manage the patient completely and needed to ask for help) and that the therapist may be acting out the transference through the referral for medication. Similarly, the countertransferential feelings of the psychiatrist may manifest in

colluding with the patient's negative transference toward the therapist and the psychotherapeutic process.

The impact of such negative transference reactions include the premature closure of the therapeutic process by the patient and a focus on medication to the exclusion of other types of therapy (Bradley 1990). The physician may unconsciously enjoy being idealized by the patient and the therapist and prescribe medications either too quickly or for too long a period of time, not appreciating the dangers of overreliance on biological interventions. To the dyadic relationship between therapist and patient (Figure 6–1, square) has been added a physician, making it a tripartite relationship (Figure 6–1, triangle), and when medication is added, this becomes a four-way relationship (Figure 6–1, circle). Distortions can arise among all four components, leading to unsuccessful treatment and care.

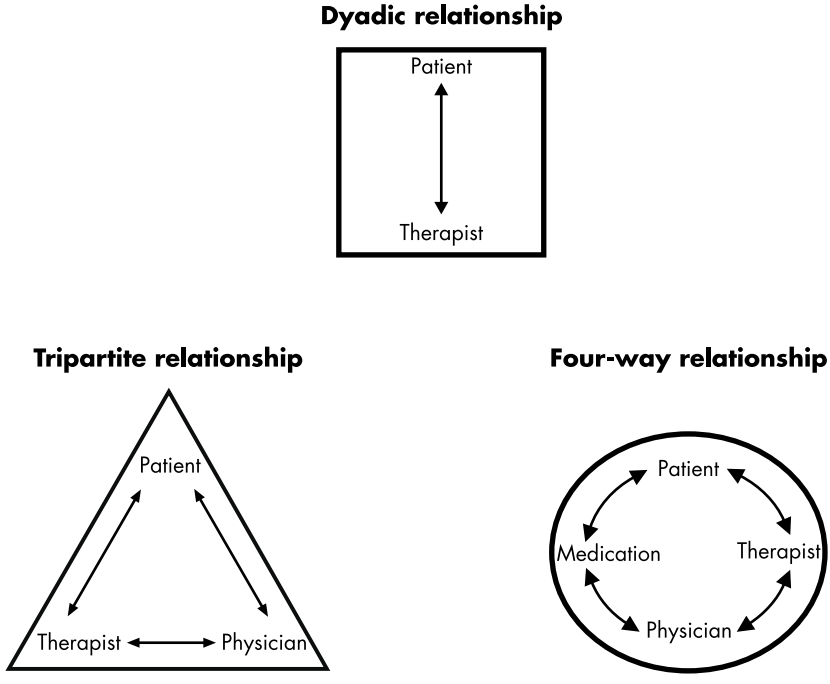

Figure 6–1. Changes in relationships as therapy and medications are added or deleted.

Legal Risks

Another significant problem is that the legal risks for psychiatrists who practice split treatment are enormous (MacBeth 1999). Given that the practice of split treatment is now almost ubiquitous, the associated legal issues are all the more troubling for the profession.

What are the sources of legal exposure? In general, there is major potential liability for all psychiatrists who prescribe psychotropics for their patients. Many problems relate to side effects of medication and whether appropriate informed consent is obtained by the physician. Patient suicide or attempted suicide is another significant source of potential liability for psychiatrists who prescribe medication.

Split treatment often heightens or magnifies such problems because patients are essentially shared, leaving the door open for miscommunication between clinicians, missing data, decreased quality of the doctor-patient relationship, and information that is viewed by the patient or clinicians as psychodynamic or physical or both. As an example, a patient who has recently started taking an antidepressant develops a headache. This event can be viewed as resistance (psychodynamic) or as a legitimate side effect (physical) or as a combination. Patients in split treatment are usually not seen as often by the psychiatrist as patients being seen by the psychiatrist for both psychotherapy and pharmacotherapy. Some psychiatrists don't get to establish the kind of doctor-patient relationship that they would if they were seeing the patient for both psychotherapy and pharmacotherapy (Riba and Tasman 2000). Similarly, the patient's family might not be as well-known to the psychiatrist. Unfortunately, this area of litigation is a burgeoning growth area for malpractice attorneys. (For an in-depth review of this subject, see MacBeth 1999.)

Ethical Challenges

Although a variety of economic, manpower, and clinical pressures have driven the growth of split treatment, there has been a startling lack of professional oversight or planning for this type

of care (Lazarus 1999). Further, little research has been done on the efficacy or efficiency of split treatment for certain types of patients (Goldman et al. 1998).

Some researchers, in fact, have suggested that managed care not be allowed to dictate split treatment to patients with borderline personality disorder because of the inherent intrapsychic splitting defense that already exists in these patients. Patients with personality disorders, especially Cluster B diagnoses (American Psychiatric Association 1994), have disordered interpersonal relationships which often manifest themselves in treatment relationships (Silk 1999). Such patients often do not tell the same story to both their clinicians (Main 1957); externalize their problems (Silk et al. 1995); threaten self-harm (Leibenluft et al. 1987); and have substance abuse and emotional lability problems (Springer et al. 1995). Such factors make treatment by a single clinician difficult. As Smith (1989) has written, "in contemporary treatment situations that include a patient, a therapist, a pharmacotherapist, and a pill, the transference issues can become more complex than the landing patterns of airplanes at an overcrowded airport" (p. 80).

When split treatment is the care of choice for a patient, there is of course no ethical dilemma. However, if cost considerations become the paramount reason for split treatment, then there are ethical concerns.

As Lazarus has noted (Lazarus 1999), there are a variety of potential conflicts when psychiatrists and nonpsychiatrists enter into split-treatment relationships. These include conflicts with or around the following:

- State licensing laws
- Competency questions
- Physicians being used as figureheads (having the authority but not really engaged in the traditional doctor-patient relationship)
- Delegation of medical judgment (by psychiatrists to nonphysician therapists)
- Financial arrangements

The American Medical Association (1999) and American Psychiatric Association (1997) have addressed some of the important issues that arise when physicians collaborate with other health and mental health professionals. Still, psychiatrists are often not clear whether they are in a supervisory, consultative, or collaborative relationship with the nonmedical therapist (American Psychiatric Association 1980), which leads to ethical dilemmas in one of the five categories listed above. Patients, too, are often not clear about how the split treatment is organized and whether or not they have options regarding such care. Further, there is often little discussion between the clinicians and the patient about what would constitute optimal care, because the type of care (i.e., split versus the psychiatrist providing both the therapy and the medication) is dictated by health care benefits, training and background of the clinicians (e.g., whether or not the psychiatrist is well-trained to provide psychotherapy), and who sees the patient first.

Clinical Case

Mr. A was in psychotherapy with a psychologist for 8 months when he started having rapid cycling of mood swings. A referral was made to a psychiatrist for evaluation and medication management. The patient continued to see both clinicians but the clinicians never spoke with one another. When the psychologist was brought up on the charge of seeing patients without a license, the patient filed an ethics complaint against the psychiatrist with the local American Psychiatric Association district branch, asserting that had the psychiatrist maintained adequate collaboration with the psychologist, this might have alerted her to the possibility of the psychologist's delivery of incompetent care.

Clinical Case

Dr. I, a very busy psychiatrist, worked in an office with three social workers and two psychologists. Over a 10-year period Dr. I became very comfortable with hearing about his patients from his colleagues and accepting their diagnoses without doing thorough and complete mental status examinations of the patients himself. Mr. B, a new patient, was seen by one of the social workers and given the diagnosis of adjustment disorder

with depressed mood. Dr. I was asked to see the patient in split treatment for medication management. When Dr. I saw Mr. B, he came into the room saying, "I understand you have some adjustment problems." Dr. I saw the patient for less than 10 minutes, did not take a good medical or psychiatric history, and prescribed an antidepressant. Soon thereafter, Mr. B was hospitalized on an emergency basis for an insulinoma. The psychiatrist was accused of delegating inappropriate authority to a nonmedical professional.

Toward Successful Split Treatment

A key aspect of split treatment is how complex and difficult such treatment is for the clinicians, the patient, and the patient's family. Unless one works in a clinic or organized setting where relationships between clinicians are well-delineated (e.g., one psychiatrist works with a specific group of nonmedical therapists), much thought must go into managing safe and effective split treatment.

It may be helpful to think of split therapy having a beginning, middle course, and end. In order to avoid or minimize the pitfalls associated with split treatment, the following clinical suggestions are provided as organizing principles for its three stages (Tasman and Riba 2000):

Beginning of Treatment

- *Communication* is key to providing excellent care in split treatment. At the beginning, both clinicians should obtain a signed release-of-information form from the patient. Communication must be regular and frequent between the clinicians and the patient should be made aware of these discussions. The forms of regular communication should be decided at the onset—routine telephone calls, faxes, e-mails, follow-up letters, and the like. The patient should not be a messenger between the clinicians.
- Issues of *confidentiality* should be discussed and reviewed at the beginning of treatment. Confidentiality should not be used as a cover to hide from taking the time to make telephone calls,

to send copies of evaluations and follow-up notes, to send e-mails or faxes, or to have joint sessions with both clinicians and the patient.

- *Diagnostic impressions* should be independently arrived at, then discussed and agreed upon. If there is a difference of opinion, an understanding must be reached before treatment proceeds.
- The clinicians must work with each other and with the patient to determine the *treatment plan.* The treatment plan should specify how often each of the clinicians expects to see the patient and what process to pursue if the patient doesn't follow up or if there is a missed appointment. If the patient wishes to end either the therapy, the medications, or both, it has to be understood that all parties will discuss this important decision.
- It is desirable for a *written contract* to be drawn up between the clinicians and the patient so that all parties understand what the agreement for services will entail. Included in the contract should be a delineation of the clinicians' roles and responsibilities as well as those of the patient.
- Clinicians' *vacation schedules and other on-call and coverage issues* must be discussed regularly and documented. The patient needs to know whom to call in an emergency.
- At the beginning of split treatment, both clinicians and the patient should be aware of their respective *beliefs* regarding medication and psychotherapy.
- There must be a discussion about *what type of care would be optimal for the patient and if there are barriers to such care.* The patient should be informed of this review; if possible, he or she should participate in it.
- The clinicians should discuss their *professional backgrounds and training* with each other at the beginning of the patient's treatment. Issues such as licensure, ethics violations, malpractice claims, hospital privileges, coverage of professional liability insurance, participation on managed care panels, and commitment to split treatment should all be made clear.
- The clinicians need to agree *who will communicate with third parties* regarding the patient's care. Further, each clinician should know the patient's mental health benefits and means of pay-

ment. There needs to be an agreement by all parties as to the use of such benefits.
- The clinicians need to understand how best to interface with the patient's *family or significant others*.
- If the patient has health providers other than the psychiatrist and therapist (e.g., primary care physician, cardiologist, physical therapist, etc.), it should decided which clinician will be the *designated communicator or coordinator* with those other providers.
- At the beginning of treatment there should be a review of how each clinician will assess and manage the patient's thoughts regarding or attempts at *suicide, homicide, violence, and domestic abuse.*
- It should be made clear to the patient *what symptoms or types of issues should be brought to the attention of which clinician.*
- It is helpful for the clinicians to decide how *problems* will be handled as the need arises.
- The clinicians should discuss differences in *fee schedules, cancellation policies, length of visits*, and *frequency of visits.*

Middle Course

- Special attention must be paid to *transference and countertransference* in this type of system of care. Disparaging and negative remarks made by the patient concerning either clinician, therapy, or medication must be understood and managed in the context of this complex type of treatment.
- Clinicians should review *how many cases of split treatment* they have in their practices and whether or not this is a safe mix. Factors to consider include the clinical complexity of the cases, how busy the practice is, the influence of third party payers and the hassle factor, the number of different clinicians one is working with, the psychiatric disorders of one's patients, and so on. It may be prudent to determine the risks involved in having a large patient population in split treatment and to weed the number of such patients down to an acceptable level. Further, clinicians should minimize the number of collaborators, since it is virtually impossible to keep track of a large

number of clinicians' credentials, vacation schedules, communication patterns, and so on.
- *Adherence to medications and to psychotherapy* should be addressed equally.
- *Treatment plans* should be regularly reviewed and updated between the clinicians and the patient.
- Use of the patient's *mental health benefits* should be regularly reviewed and discussed between the clinicians and the patient when appropriate.
- There must be an *agreement that either clinician can terminate the split therapy* but that the patient must be provided adequate and appropriate warning and referrals to other clinicians. In other words, the patient cannot be abandoned.

Ending Split Treatment

- After reviewing the treatment plan, both clinicians and the patient will decide together on the *goals* that have been met or have not been realized and the *best time for termination*. They should decide how to stagger the discontinuation of therapy and of medication.
- It is important to consider how to manage *follow-up* and *recurrence of symptoms*.

The clinicians must have a system for giving each other feedback on the care each is providing to the patient. Ideally, after the treatment is complete, the clinicians should review any aspects of the case that could have been managed or handled differently. Ideally, the patient should be part of this evaluation process as a way of assuring continuous quality improvement. Most importantly, throughout all stages of the split treatment process, clinicians need to respect both the patient and each other's professional understanding.

Although the challenges of split treatment are great, there are many reasons for clinicians and patients to try to surmount the obstacles. Good communication patterns between clinicians and many of the suggestions noted here may be guideposts on the path toward successful split treatment.

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Afterword

Jerald Kay, M.D.

For many reasons, not the least of which is significantly improved care for our patients, it is very heartening that clinicians and researchers have finally devoted attention and study to integrated treatment. That the series editors of the *Review of Psychiatry* chose to include this topic speaks of its increasing relevance to clinical practice. Moreover, given the little overlap in content of the chapters of this book, it is clear that there is increasing interest in the multiple facets and applications of this treatment approach. Taken as a whole, this book emphasizes the imperative task of providing the most comprehensive care for our patients not only through supporting clinical research, but also by resolving long-lived and distracting theoretical tensions. A number of chapter authors have alluded to the continuing dualism in our approach to treating those with psychiatric disorders, a dualism that has been distracting and unhelpful to the field.

Throughout the last 25 years there has been remarkable progress in our development of new compounds to treat mental illness and in our understanding of the neurobiological aspects of mental illness. There is now ample scientific evidence that psychotherapy, not unlike pharmacotherapy, changes brain structure and function. With exciting findings from cognitive neuroscience and brain imaging, we are in a position to document with increasing accuracy and conviction the efficacy and cost effectiveness of our interventions. In light of the mounting evidence supporting integrated treatment for many disorders, it would indeed be short-sighted to jettison psychotherapy as a core clinical skill for psychiatrists.

For the future, clinical practice and research must address a number of central issues. These include, but are not limited to, the following:

- Which psychotherapies are most effective for integrated treatment in what disorders?
- For which psychiatric disorders should sequential treatment be used, and in what order should the psychotherapy and medication be prescribed for these disorders?
- In what circumstances is it more clinically effective and cost effective for psychiatrists to provide integrated treatment rather than split treatment?

I am deeply appreciative of the contributions from the authors of this volume. They have provided the most up-to-date clinical advice and wisdom available for improving the care of our patients and moving toward a more sophisticated definition of our field.

Index

*Page numbers printed in **boldface** type refer to tables or figures.*

AA Member—Medications and Other Drugs (Alcoholics Anonymous World Services 1984), 83
Acamprosate, **89**
Acting out, 35
Action stage, of motivational enhancement therapy, 87
Addiction. *See* Substance use disorders
Affective disorders, and medication in subsyndrome cases, 46
Affective subtype, of borderline personality disorder, 54, **68**
Agency for Health Care Policy Reform (U.S. Department of Health and Human Services), 103
Aggressive subtype, of borderline personality disorder, 54–55, **68**
Agoraphobia, and panic disorder, 14
Alcoholics Anonymous (AA), 83. *See also* Twelve-step programs
Alcohol use disorders, **89,** 96–97
Amantadine, **89**
Ambivalence, and patients with substance use disorders, 81
American Medical Association, 146, 157
American Psychiatric Association
  Commission on Psychotherapy by Psychiatrists, 146
  Practice Guideline for Borderline Personality Disorder, 17, 51–52, 60
  Practice Guideline for Treatment of Patients with Substance Use Disorders, 80, 102, 103
  Practice Research Network (PRN), 1
  split treatment and, 144, 157
Anticipation, of crises in treatment plans for borderline personality disorder, 69
Antidepressants. *See also* Tricyclic antidepressants
  conflicts between psychodynamic theory and medication, 46–47
  eating disorders and, 15–16

Antidepressants *(continued)*
generalized anxiety disorder and, 14
panic disorder and, 14
psychodynamic clinicians and, 38
public opinion and, 145
Anxiety disorders
conflicts between psychodynamic theory and medication, 45
efficacy of integrated treatment for, 13–16
medication use in subsyndrome cases of, 46
substance use disorders and comorbidity, 91
Assessment, of borderline personality disorder, 52–61
Attention-deficit hyperactivity disorder (ADHD), 130
Automatic thoughts, and compliance with medication, 114, 115, **116,** 135–136
Axis I and Axis II disorders
comorbidity and borderline personality disorder, 56–57, 62–65
psychodynamic theory and, 40–41

Barbiturates, **89**
Beck Depression Inventory, 38
Behavior therapy. *See also* Cognitive-behavioral therapy; Dialectical behavior therapy
compliance with medication and, 126–127
nicotine dependence and, 102–103
obsessive-compulsive disorder and, 15
opioid dependence and, 95–96
Beliefs, and compliance with medication, 115, **116–117, 118, 119,** 139
Benzodiazepines
generalized anxiety disorder and, 14
personality disorders and, **18**
substance use disorders and, **89**
Biopsychosocial approach, to treatment. *See also* Psychosocial treatments
borderline personality disorder and plan for, 61–72
direction of psychiatry and, 2–3
resistance to integrated treatment and, 4
Bipolar disorder, 10
Borderline personality disorder
assessment of, 52–61
characteristics of, **53**
integrated treatment and, 51–73
frequency, 51
practice guidelines for, 17, 51–52, 60
psychoanalytic psychotherapy and, 16–17
split treatment of, 150
Borderline personality organization, 52
Brief dynamic psychotherapy, and panic disorder, 13–14
Brief Psychiatric Rating Scale, 12
Buprenorphine, **89,** 92
Bupropion, 102

Carbamazepine, **18**
Center for Psychoanalytic Training and Research (Columbia University), 37–38
"Chain analysis," and dialectical behavior therapy, 69
Clinical cases, of integrated treatment
  borderline personality disorder and, 58–60, 62–65, 70–71
  compliance with medication and, 114–115, 117–120, 123–125, 129–132, 133–134, 136–138
  conflicts between psychodynamic theory and medication, 34–36
  personality disorders and, 17, 19–20
  potential benefits of, 5–6, 7
  sequencing treatments and, 43–45
  split treatment and, 143, 146, 147–150, 151–152, 157–158
  substance use disorders and, 84–85, 88
Clinical management (CM), and cocaine use disorders, 101
Clinical practice. *See also* Clinicians
  conflicts between medication and psychodynamic theory and, 45–48
  future of integrated treatment and, 166
  sequencing treatments and, 43–45
Clinicians. *See also* Clinical practice; Countertransference; Psychiatrists; Therapists; Transference
  antidepressants and psychodynamic, 38
  benefits of split treatment and, 147–151
  general recommendations on integrated treatment and, 22–24
Clomipramine, 13–14
Clonidine, **89**
Clozapine, 12
Cocaine Collaborative Study, 100
Cocaine use disorders, 16, **89,** 100–102
Cognitive-behavioral therapy (CBT). *See also* Behavior therapy; Cognitive therapy
  borderline personality disorder and, 65, 72
  depression and, 9, 10
  eating disorders and, 15–16
  generalized anxiety disorder and, 14
  panic disorder and, 13, 14
  schizophrenia and, 12
  substance use disorders and, 93, 96–97, 99, 100–101
Cognitive conceptualization diagram, **120, 121**
Cognitive therapy, and compliance with medication. *See also* Cognitive-behavioral therapy
  model of noncompliance and, 114–120
  prevention of problems with, 121–124

Cognitive therapy, and compliance with medication *(continued)*
techniques to increase compliance, 127–139
uncovering of noncompliance and, 124–125
Collaborative treatment, of substance use disorders, 80. *See also* Split treatment
Combined treatment. *See* Integrated treatment; Split treatment
Communication, and split treatment, 153, 158
Comorbidity, of psychiatric disorders
borderline personality disorder and, 56–57, 62–65, 69
substance use disorders and, 90–91, 101–103, 104
Compassionate admonition, and borderline personality disorder, 72
Compliance, with medication
behavioral techniques to increase, 126–127
cognitive model of, 114–120
cognitive techniques to increase, 127–139
identification of obstacles to, 113
potential benefits of integrated treatment and, 6
prevention of problems with, 121–124
split treatment and, 151, 161
substance use disorders and, 83, 95, 97, 104
uncovering of noncompliance and, 124–125
variation in, 113
Confidentiality, and split treatment, 158–159
Conflicts, between psychodynamic therapy and medication
changing attitudes on, 36–42
clinical recommendations and, 45–48
historical review of, 32–36
integrated model and, 42–43
sequencing treatments and, 43–45
split treatment and, 156
Consultation, and conflicts between psychodynamic theory and medication, 46
Contemplation stage, of motivational enhancement therapy, 86, 87
Contingency contracting, and opioid dependence, 93–94, 95–96. *See also* Contracts
Continuum, of interventions for borderline personality disorder, 72
Contracts, and integrated treatment. *See also* Contingency contracting
alcohol use disorders and, 97–98
borderline personality disorder and, 60, 66
split treatment and, 159
Control master theory, for addiction, 82
Coping cards, and compliance with medication, 127, **129, 132, 134,** 135, **137, 138**

Coping skills, and substance use disorders, 81–82, 99
Cost
efficacy of integrated treatment for depression and, 9
efficacy of integrated treatment for substance use disorders and, 16
split treatment and, 145, 148, 156
studies of integrated treatment and, 2
Countertransference. *See also* Transference
clinicians and management of, 22
conflicts between psychodynamic theory and medication, 47–48
personality disorders and, 20, 150
potential benefits of integrated treatment and, 5
split treatment and, 153, 160
Couples therapy, and alcohol use disorders, 98. *See also* Family therapy
Covert rehearsal, and compliance with medication, 123
Crisis management, and borderline personality disorder, 69–71
Culture, and split treatment, 149

Defenses, and benefits of pharmacotherapy, 5
Dependent subtype, of borderline personality disorder, 55, **68**
Depression. *See also* Major depression; Mood disorders; Unipolar depression
borderline personality disorder and comorbidity with, **64**
conflicts between medication and psychodynamic interpretation of, 35–37, 38, 45
efficacy of integrated treatment for, 8–11
study on cost effectiveness of integrated treatment for, 2
substance use disorders and comorbidity, 102
Designated communicator or coordinator, and split treatment, 160
Desipramine, **89**
Diagnostic impressions, and split treatment, 159. *See also* Assessment
Dialectical behavior therapy (DBT), and borderline personality disorder, 65–66, 69. *See also* Behavior therapy
Discontinuation, of medication, 22
Disulfiram, 83, **89,** 97–98
Doctor-patient relationship. *See also* Therapeutic alliance
conflicts between psychodynamic theory and medication, 46
split treatment and, 154
Dose-response relationship, and psychotherapy for opioid dependence, 93
Drug Addiction Treatment Act of 2000, 92

DSM-III, and borderline personality disorder, 52
DSM-IV, and borderline personality disorder, 55
DSM-IV-TR, and borderline personality disorder, 52, 54, 55–56
Dual recovery therapy (DRT), and cocaine use disorders, 101–102
Dyscontrol, and efficacy of medications, **18**
Dysthymia
  efficacy of integrated treatment for, 10
  psychodynamic theory and, 37, 38

Eating disorders, 15–16, 150
Education. *See also* Psychoeducation; Residency training
  compliance with medication and, 122, 128–129
  schizophrenia and, 12
  split treatment and, 144, 151
Ego functions, 5
Elderly, and integrated treatment for depression, 8
Emotions
  benefits of split treatment for clinicians and, 150
  patients with substance use disorders and, 82
Empty subtype, of borderline personality disorder, 55–56, **68**
Ethics, and split treatment, 155–158
Expressed emotion, and families of schizophrenia patients, 11
Extensive personality disorder, 56

Family. *See also* Family therapy; Interpersonal relationships
  alcohol use disorders and spousal support, 97–98
  schizophrenia and, 11, 13
  split treatment and, 160
  substance use disorders and, 84, 104
Family therapy. *See also* Couples therapy; Family
  borderline personality disorder and, 66
  efficacy of integrated treatment for bipolar disorder and, 10
Fantasies, and mind-body dualism, 40–41
Five-type etiological model, of borderline personality disorder, 54–56
Flexibility, in treatment of borderline personality disorder, 71–72
Fluoxetine, 70
Follow-up, and split treatment, 161
Freud, Anna, 33

Generalized anxiety disorder, 14
Group therapy
  borderline personality disorder and, 66
  dysthymia and, 10
Guidelines
  borderline personality disorder and, 17, 51–52, 60
  split treatment and, 144
  substance use disorders and, 80, 102, 103
Guilt, and patients with substance use disorders, 82

Hamilton Rating Scale, 47
Heroin dependence, 88, 92–95
History, of integrated treatment
  relationship between medication and psychodynamic therapy, 32–36
  resistance to combined treatment and, 4
  split treatment and, 144

Imagery, and compliance with medication, 137–138
Imipramine, 9–10, 13
Impulse control, and borderline personality disorder, 54
Impulsive subtype, of borderline personality disorder, 54, **68**
Individual drug counseling (IDC), and cocaine use disorders, 100
Individual psychotherapy, and schizophrenia, 11–12
Informed consent, and split treatment, 155
Insight, and psychodynamic theory of depression, 38
Integrated treatment
  benefits of, 1–2, 4–7
  borderline personality disorder and, 51–73
  compliance with medication and, 113–139
  conflicts between psychodynamic therapy and medication, 31–49
  definition of psychiatry and, 2–3
  efficacy of, 8–20
  future of, 166
  historical resistance to, 4
  recommendations for clinicians on, 22–24
  split treatment and, 143–161
  substance use disorders and, 79–104
  unanswered scientific questions on, 20–21
Interpersonal psychotherapy
  borderline personality disorder and group, 66
  efficacy of compared to integrated treatment for depression, 9
Interpersonal relationships. *See also* Family
  personality disorders and, 60, 156
  substance use disorders and, 84

Learning, and psychotherapy, 3
LAAM, **89,** 92
Legal risks, of split treatment, 155
Lifestyle, and substance use disorders, 81, 82
Listening to Prozac (Kramer 1993), 145

Maintenance stage, of motivational enhancement therapy, 87
Major depression. *See also* Depression
  borderline personality disorder and, 64, 65
  efficacy of integrated treatment for, 8
  psychodynamic theory and, 38
Managed care, and cost incentives for integrated treatment, 3, 145, 156
Melancholic depression, 39
Metapsychology, 49

Methadone, and opioid use disorders, 16, **89,** 92–95
Mind-body dualism
biological versus psychosocial view of psychiatry and, 3
psychodynamic theory and, 39, 40–42
Monitoring log, and compliance with medication, 127
Monoamine oxidase inhibitors (MAOIs)
borderline personality disorder and, 70, 71
personality disorders and, **18**
Mood disorders. *See also* Depression
efficacy of integrated treatment for, 8–11
substance use disorders and, 90
Motivational enhancement therapy (MET), 86–87, 96–97
Motivation, of patient
borderline personality disorder and, 58–61
compliance with medication and, 134
substance use disorders and, 81, 86–87

Nalmefene, **89**
Naloxone, 92
Naltrexone
alcohol use disorders and, **89,** 99–100
compliance and, 83
opioid dependence and, 95–96
National Council on Alcohol and Drug Information (NCADI), 85
National Institute on Alcohol Abuse and Alcoholism (NIAAA), 96
National Institute of Drug Abuse, 100
Nefazadone, 9
Neuroleptic agents, **18**
Neuroscience
developments in psychiatry and, 3
substance use disorders and, 79
Nicotine dependence, **89,** 102–103
Nicotine replacements, **89,** 102
Nortriptyline, 8, **89**

Obsessive-compulsive disorder
efficacy of integrated treatment for, 15
psychodynamic concepts and, 37
sequencing treatment and, 43–45
Odansetron, **89**
Office-based treatment, of opioid dependence, 92
Opioid agonist medications, and substance use disorders, 88
Opioid use disorders, 16, **89,** 91–96

Panic attacks, 14
Panic disorder
efficacy of integrated treatment for, 13–14
psychodynamic theory and, 42
Partial hospitalization programs, for opioid dependence, 94
Personality disorders. *See also* Borderline personality disorder
efficacy of integrated treatment for, 16–20

split treatment and, 155
substance use disorders and, 91
Phenomenology, and psychodynamic view of symptoms, 39–40, 49
Physicians
distinction between psychiatrists and, 3
office-based treatment of opioid dependence and, 92
split treatment and, 144
Placebo effect, and pharmacotherapy, 5
Posttraumatic symptoms, and substance use disorders, 91
Precontemplation and preparation stages, of motivational enhancement therapy, 86–87
Professional support, and split treatment, 150–151
Prognostic factors, in borderline personality disorder, 57–58
Project MATCH (Matching Alcoholism Treatment to Client Heterogeneity), 96
Psychiatrists. *See also* Clinicians; Psychiatry; Residency training; Therapists
patients' feelings about, **21**
study on prevalence of integrated treatment and, 1, **2**
Psychiatry, integrated treatment and definition of, 2–3. *See also* Clinicians; Psychiatrists; Psychotherapy; Residency training
Psychoanalytic psychotherapy
borderline personality disorder and, 16–17
conflicts between psychodynamic theory and medication and, 46
Psychodynamic psychotherapy and theory. *See also* Conflicts
borderline personality disorder and, 65, 66
conflicts between psychopharmacology and, 32–48
efficacy of integrated treatment for panic disorder and, 13–14
symptoms and, 32–33
Psychoeducation. *See also* Education
compliance with medication and, 115, 130
schizophrenia and, 12
Psychological Mindedness Scale, 38
Psychopharmacology. *See also* Antidepressants; Compliance; Side effects; *specific medications*
borderline personality disorder and, 67–68
conflicts between psychodynamic theory and, 32–48
efficacy of medications for dyscontrol, **18**
patients' feelings about, **21**
resistance to integrated treatment and, 4
substance use disorders and, 79, 88–91
Psychosocial treatments, and substance use disorders, 82, 84, 94–95, 97, 99, 103–104. *See also* Biopsychosocial approach

Psychotherapy. *See also* Cognitive-behavioral therapy; Family therapy; Group therapy; Individual psychotherapy; Interpersonal psychotherapy; Psychoanalytic psychotherapy; Psychodynamic psychotherapy and theory; Supportive psychotherapy
alcohol use disorders and, 96–97
borderline personality disorder and, 65–66
definition of, 1, **2**
family of schizophrenia patients and, 13
neurobiology study of, 3
pharmacotherapy and interruptions of, 5
prescription of medication within context of, 23
substance use disorders and, 81–88, 93
termination phase of, 23

Quality-of-life-interfering behavior, and borderline personality disorder, 66

Readmission rate, and efficacy of integrated treatment for schizophrenia, 11
Recommendations, on integrated treatment
for clinicians, 22–24
conflicts between psychodynamic theory and medication, 45–48
substance use disorders and, 103–104
Recovery Status Examination, 86, 104
Recurrence. *See also* Relapse
of depression after integrated treatment, 8
of symptoms after split treatment, 161
Refusal, of medication, 19–20
Reinforcement, and substance use disorders, 81
Relapse, and efficacy of integrated treatment. *See also* Recurrence
panic disorder and, 14
schizophrenia and, 11–12
Relapse prevention therapy, and substance use disorders, 81–82, 87
Research, on integrated treatment. *See also* Neuroscience
methodological problems in, 11
need for future, 24, 166
Residency training, and psychiatry. *See also* Education; Psychiatrists; Psychiatry
psychotherapy and, 3
split treatment and, 146
Response prevention, and obsessive-compulsive disorder, 15

Safety, and therapeutic relationship, 5
Schizoaffective disorder, 10
Schizophrenia
efficacy of integrated treatment for, 11–13
psychodynamic theory and, 39
substance use disorders and, 102

Schizotypal personality disorder, 71
Selective serotonin reuptake inhibitors (SSRIs), 15, 71
Self, and patient's fear of medication, 41
Self-defeating behaviors, and substance use disorders, 83–84
Self-esteem, of patient, 4
Self-help groups, and substance use disorders, 86
Self-medication, and substance use disorders, 82
Sequencing treatments, 43–45
Serotonin reuptake inhibitors (SRIs), **18**
Sertraline, 10
Side effects, of psychopharmacology
  potential benefits of integrated treatment and, 5
  recommendations to clinicians and, 22–23, 46
  split treatment and, 155
Single-treater model, of treatment for borderline personality disorder, 61
Social phobia, 14
Social skills training, and schizophrenia, 12
Social support, and substance use disorders, 84, 98, 104
Socratic questions, and compliance with medication, **136**
Spirituality, and treatment of substance use disorders, 83
Split treatment
  conflicts between psychodynamic theory and medication, 46
  factors in successful, 158–161
  history of, 144
  increase in use of, 145
  negative aspects of, 152–158
  positive aspects of, 147–152
  psychiatric resident training and, 146
  terminology and, 144, **145**
Stages-of-change model, and substance use disorders, 86–87
Stress, and borderline personality disorder, 69
Substance use disorders
  alcohol use disorders and, 96–100
  borderline personality disorder and, 69
  cocaine use disorders and, 100–102
  collaborative treatment efforts and, 80
  efficacy of integrated treatment for, 16
  neuroscience and, 79
  nicotine dependence and, 102–103
  opioid dependence and, 91–96
  pharmacotherapy for, 79, 88–91
  practice guideline on, 80
  psychotherapy for, 85–88
  recommendations on, 103–104
Subtypes, of borderline personality disorder, 52–56, **68**
Suicide and suicidal ideation
  borderline personality disorder and, 17, 65–66, 69
  split treatment and, 155, 160

Supportive counseling, and opiate dependence, 16
Supportive-expressive psychotherapy, and substance use disorders, 16, 93
Supportive psychotherapy
alcohol use disorders and, 99
eating disorders and, 15
Symptoms
chronic substance use and, 91
psychodynamic theory and, 32–33, 39–40, 49
psychopharmacology for borderline personality disorder and, **67**
split treatment and, 160

Termination, of integrated treatment, 23, 161
Therapeutic alliance. *See also* Doctor-patient relationship
compliance with medication and, 122
importance of, 22
substance use disorders and, 81, 103
Therapists, treatment of borderline personality disorder and number of, 61–62. *See also* Clinicians; Psychiatrists
Therapy-interfering behavior, and borderline personality disorder, 66
Thoughts, and compliance with medication, 114, 115, **116,** 135–136
Tiapride, **89**
Timing, of medication for substance use disorders, 88–90
Transference. *See also* Countertransference
clinical case and, 35
medication and patient's concept of self, 41
personality disorders and, 20
split treatment and, 153–154, 156, 160
Treatment framework, for borderline personality disorder, 60–61
Treatment plans
borderline personality disorder and, 61–72
split treatment and, 151, 159, 161
Triage system, and split treatment, 148
Tricyclic antidepressants. *See also* Antidepressants
depression and, 8
eating disorders and, 15
panic disorder with agoraphobia and, 14
personality disorders and, **18**
Twelve-step programs, and substance use disorders, 83, 85–86, 96–97, 100, 101, 104
Two-treater model, for treatment of borderline personality disorder, 61–62

Unipolar depression, and efficacy of integrated treatment, 8–10. *See also* Depression
U.S. Public Health Service, 103

Vacations, of clinicians, and benefits of split treatment, 147, 159

Validation, and treatment of borderline personality disorder, 72
Valproate, **18**
Violent behavior, and split treatment, 160
Withdrawal, and treatment of substance use disorders, 89–90
Women, and efficacy of integrated treatment for depression, 9–10