

CHAPTER 5

**A Physician, a Nonmedical
Psychotherapist,
and a Patient: The
Pharmacotherapy-
Psychotherapy Triangle**

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The psychiatric research literature contains strong evidence to suggest the combination of ps Psychotherapy and pharmacotherapy is useful in depression schizophreina, and anxiety states. The research literature also supports, combined treatment in a variety of other disorders, eg, alcholoism, ppolydrug abuse and anorexia nerveosa. Comprehensive reviews of many of these indications are contained elsewhere in this book. While many psychiatrists provide their patients with both psychotherapy and pharmacotherapy, these

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Table 2. Comparing Psychologists Who See Psychotherapy Patients in Triangles with Those Who Do Not

Mean age	43.4 vs 46.5	p - 0.08
Mean year of PhD	71.3 vs 68.2	p <0.05
Mean hours/week of psychotherapy	23.3 vs 8.8	p <0.001

see patients in combined treatment tend to be younger, have received their degrees more recently, and have relatively more extensive clinical practices. They are as likely to initiate referrals to pharmacotherapists as they are to receive referrals from pharmacotherapists.

These data indicate that treatment triangles are frequently formed. Nonphysician psychotherapists cannot prescribe drugs, and therefore need physicians for their medication-taking patients. They are increasingly aware of the efficacy of psychopharmacology and treatments. On the other hand, a physician can deliver both modes of therapy, but may find that the limitations of time and knowledge prevent him/her from doing so. Medication management involves an awareness of internal medicine; the psychopharmacological literature can occupy much of one's professional reading time. Psychotherapy is increasingly specific, with increasingly more information available in interpersonal/family therapy, group therapy, various forms of cognitive/behavior, and the psychodynamic therapy. Many psychiatrists are now basing their practice on a knowledge of diagnosis, pharmacology, psychosomatic interplay, and a more thorough physical understanding of the patient [1-3]. They will assess and then manage the medication of patients doing psychotherapeutic work with other professionals. A physician can refer to nonmedical psychotherapists, or vice versa. The result is a three-way therapeutic interaction and contract. This "therapeutic triangle" if attended to, can provide the patient with a richer treatment program, infused with ideas from two different perspectives and academic backgrounds. This chapter reviews a number of aspects of the psychotherapy/pharmacotherapy triangle. We begin with the format: how to set one up, and what guidelines to follow.

INITIATION OF THE TRIANGLE

Success in a triangular relationship is enhanced by attention to detail. The patient must have not only an individual contract with each therapist, but also a contract for all three participants, spelling

out such matters as the time and place the therapists and/or patient will meet to discuss the triangular arrangement, the fee for such a meeting, and its goals. Each therapist should maintain a set of written records for his/her individual work. A format for recording events in the three-way contract should also be worked out. Generally, we recommend that the therapist initiating the three-way action take responsibility for writing notes on the triangular contract throughout the course of treatment, and send a copy of these notes to the other therapist. A basic rule in establishing triangular arrangements is that the current therapist should never commit the other therapist to a course of treatment. A patient should never be told that he/she will be given medication or psychotherapy. A referral should always be something like, "this might be a good idea, let's see what my colleague thinks."

Ideally, the patient and both therapists meet to clarify the triangular arrangement. Although the therapists may be quite comfortable with one another, there is no substitute for face-to-face contact to establish the rules, especially in the patient's mind. Consider the situation in which the nonmedical therapist is initiating the triangular arrangement. He contacts the psychopharmacologist, gives a case description, and receives an initial impression about possible medications. The MD then meets and evaluates the patient and, if medication is appropriate, has the option of starting treatment and setting up a schedule for monitoring and follow-up. At this point, the initial three-way interview may be set up. The therapists should agree on the time, place, and fee for this meeting and the referring therapist should notify the patient.

DISCUSS THE REASONS FOR BOTH THERAPIES

Each therapist should attempt to let the patient know his/her role differences and similarities. This orientation reduces confusion, establishes a format for keeping objectives clear during treatment, and increases each therapist's ability to work toward compliance with the total plan. Usually, the referring therapist initiates the discussion by presenting the patient with a model of psychopathology and of treatment. The problem, or illness, or syndrome, should be discussed in ways which integrate biological and psychological mechanisms. These explanations should be tailored to the patient's

explanatory model or personal theory of the disease [4]. The reviews of combined therapy in other chapters of this book may provide data

for this discussion. The therapists may emphasize to the patient that the success of any therapy is dependent on a good initial evaluation and on continuous gathering of information. Introducing this idea early in the discussion may help in handling the crucial issue of confidentiality.

The issue of combining medication and psychotherapy may be approached in a general way. For example, "Medication can relieve many of the symptoms of anxiety and depression. You may notice increasing energy or clarity in your thinking. However, medications do not teach you new behaviors, and they do not change inter-personal situations. These areas may be approached by psycho-therapy." This introduction makes sense to most patients, and may lead to a more explicit discussion of the treatment plan.

REVIEW INDIVIDUAL CONTRACTS

The review of individual contracts can be handled briefly. Each therapist should state the frequency of contact and estimate the duration of treatment in his/her modality. Pharmacotherapy often involves more intense initial evaluation, followed by infrequent checks as efficacy and adverse effects are well established. Psycho-therapy often requires more frequent meetings over a longer period of time.

REVIEW TRIANGULAR CONTRACT

Confidentiality is a crucial issue for the treatment triangle. The therapists must be free to discuss any aspects of the case with one another; an envelope of confidentiality now encloses three, not two people. New ideas may occur to patient or therapist at *any* time, and patients may, for a variety of reasons, give information to one therapist but not to another. Patients may be offered an example or two here. For example:

A 62-year-old man began therapy with a clinical psychologist because of depression. His spouse had died six months earlier. Because he noted vegetative signs of depression, the psychologist obtained psychiatric consultation. The psychiatrist pre-scribed an antidepressant medication and both the therapists outlined the parameters of confidentiality. Later, the patient

told the psychologist he was worried about his drinking. He had denied alcohol difficulties during his medical evaluation. The psychiatrist was told discussed drug-alcohol interactions with the patient. Alcohol management became part of the treatment for both therapists. The patient's reluctance to discuss alcohol with the physician was based on a past experience with another physician who had become "extremely angry" with him when he reported his drinking.

If need be, the patient can be assured that while all information is open to exchange, most of what the patient brings up will not be discussed in detail between the therapists. Each therapist needs to know the other's general impression of how the patient is doing and what changes in treatment plan have occurred. They are likely to discuss in greater detail problems of mutual concern like the alcoholism of the patient in the previous case. The therapists should also consider having regular contact with one another during the joint treatment. This communication can be done face-to-face, by phone, or by note, depending on the circumstances. The patient should know the schedule for this contact, and what additional fee, if any, is involved.

When a patient gives new information to one therapist, we encourage him/her to give it to the other, with the understanding that even if this does not happen, the therapists will talk about it in their next contact.

ISSUES OF JOINT CONCERN

Once the two therapies have been initiated, there will be many areas of overlap. One is *universal—compliance* and another is fairly complex when it arises—the monitoring *of suicidal behavior*. Compliance is a troublesome issue in any health care delivery system. Securing a patient's active participation in a treatment program is an important task in any psychotherapeutic endeavor. Fortunately, the most direct way to do this is also the most efficacious [5]. Patients should be asked, in a friendly and helpful manner, whether or not they are following the guidelines of the treatment plan. Questions may be relatively simple: "Are you taking your medications as directed?" "How is your job hunting going?" "Are you and your spouse finding some time each day to practice new sexual techniques?" To do this effectively, the therapists must understand and

accept the total treatment plan. Each therapist needs to adopt a "cheerleading," supportive stance toward the work of the other. In each session, each therapist may consider asking about progress, praising compliance, and encouraging continuation of the treatment program. If the patient is not following the treatment plan, then some inquiry is necessary. When hearing the patient's report of some outrageous act by the other therapist, each therapist should avoid the impulse to grimace, make a fist, or say "He did what? That's terrible!" What follows are two examples of these discussions; the psychotherapist reviewing pharmacotherapy, and the pharmacotherapist reviewing the psychotherapy.

PhD: How is your drug treatment going? Are you taking your medication as directed?

Pt: Well, some of the time.

PhD: I know it's hard to stick with a program day after day, but with this medication you must take it as directed. When you do not take it, what gets in the way?

Pt: I just forget. I am supposed to take it twice a day. Sometimes I miss one dose, sometimes I miss both doses.

PhD: That does happen, but fortunately, there are ways to help you remember. Any other reasons why you sometimes miss a dose?

Pt: Well, to tell the truth, this stuff makes my mouth dry and I don't like that.

PhD: That may be a side effect of the medication, and it is important to talk to Dr. Jones about both the dry mouth and ways of remembering to take the medicine. What you need to do is make a special effort to take the pills as directed, and bring up both these points in your next meeting with Dr. Jones. I will be sure to mention to him that you have these two concerns.

And:

MD: How is your psychotherapy going?

Pt: So-so.

MD: Are you having some difficulties with it?

Pt: It's Dr. Smith. She seems kind of cold. Not like you. You seem to understand me better.

MD: Psychotherapy can stir up strong emotions. Please consider discussing your feelings over with Dr. Smith. It may

be hard, but talking about negative feelings often leads to good results in the kind of therapeutic work you are doing. I'll be checking with her in two weeks. My hunch is you'll be glad you talked over these emotions with her.

Please notice, especially in the second example, that the colleague is supported, splitting is avoided, and an issue that may involve transference problems is referred, in a positive way, to the appropriate therapist.

i 1 The *suicidal* patient is often most difficult. There is no current pharmacological treatment for suicidal behavior, although several interesting avenues are currently under investigation [6]. However, suicidal behavior is found in patients with a variety of psychiatric illnesses and these illnesses are often treated by pharmacologic means. The disorder most frequently associated with suicidal behavior is depression this diagnosis is made 28 percent of the time among male suicide attempters, and 40 percent of the time among female suicide attempters [7].

Suicidal behavior has also been reported in increased frequency with disorders, especially when they are associated with panic attacks [8]. Both anxiety and depression are likely to respond to pharmacological intervention. This fact is troublesome since anti-anxiety agents and antidepressant agents are frequently used in deliberate overdose; however, the frequency of suicide in psychiatric patients [9] is low enough that it should not interfere with effective treatment. If a patient has suicidal ideation, and/or has a past history of suicide attempts, these issues should be addressed in the triangular meeting. The therapists should emphasize that no medication works unless it is taken as directed. Many suicide attempters are impulsive, and this characteristic should be addressed as an important issue for psychotherapy. The patient and both therapists should agree upon a contract for a reasonable period of time, perhaps six weeks in the case of antidepressants, during which the medication is to be taken as directed and not to be used in any self-destructive way. Many patients will cooperate with a time-limited contract which looks for potential benefits from medication. They will respond less well to medication prescribed for an indefinite period of time and for vague reasons. As noted before, nonmedical therapists can help by asking about compliance. Additionally, both therapists should monitor suicidal ideation and behavior and be alert to the hints the patient is

sequestering medication. Careful notes about these discussions are essential. Potentially suicidal patients should be given frequent prescriptions containing nonlethal amounts of medication. Whether prescriptions for these small amounts are handled by the psychotherapist in the regular weekly meeting or by increased frequency of meeting with the pharmacotherapist is a question to be negotiated.

Patients often suffer from pharmacologically treatable psychiatric illness and also have troublesome personality traits, as discussed by Ward in Chapter 3. These personality traits must be taken into account in relationship development and compliance enhancement. The therapists should consider discussing these traits, and develop a "party line" approach so that the patient will find some consistency in each therapist's style. A dependent patient may respond best to a warm and somewhat global explanation about recommendations, while an obsessive patient might need extensive detail, and might view warmth suspiciously. One patient may be able to collaborate fully and do well with a flexible approach. Another may respond best to a high degree of authority. Therapists consulting about their approaches to a patient often get to know each other a little better and do some mutual teaching. Usually, differences of opinion about approaches to a patient can either be resolved or understood and tolerated.

EMERGENCIES

In the initial meeting, the possibility of emergencies should be raised. Each therapist should develop a way of handling emergencies in their individual work, and these procedures should be explained to the patient. At times, the therapist who should handle a specific emergency is obvious. For example, interpersonal disruptions are often best handled in the context of the ongoing psychotherapy, while extrapyramidal reactions to the antipsychotic medication are clearly in the province of the psychopharmacotherapist. Other situations are less clear. For example, a sudden feeling of dysphoria and confusion could have one of many causes. Patients are not required to sort out responsibilities in the case of emergencies and should be permitted to contact either therapist. If hospitalization is an issue, the psychiatrist is usually more likely to handle the decision.

OTHER ISSUES

A host of other issues may enter the triangular arrangement and may need to be stated explicitly in the contract. If supervision is involved, the patient may be informed, told why, and understand his/her responsibility in the matter, ie, will he/she be charged for the time? Is either therapist expecting the other to provide coverage for vacation? A pharmacotherapist who has been meeting with a patient for 15 minutes a month may be startled when suddenly being told by a patient that the psychotherapist is out of town for two weeks and he/she would like an hour appointment to "talk things over." Vacation coverage can be a helpful addition to a triangular relationship, giving the patient a familiar person as back-up, but the arrangement must be spelled out beforehand.

Couples in therapy present a special problem to triangular arrangements. Some times, as couples engage in psychotherapy, one of the pair develops psychiatric symptoms, and receives a referral for pharmacotherapy. While medication may be useful, it also may invalidate, in the nonmedicated spouse's mind, the usefulness of the couple's work. "Now, clearly, I can see that it's not me, it's him (or her). He is sick, and needs medication." When a couple is in ongoing therapy, the psychopharmacotherapist should consider seeing both patients initially. Medication should be discussed in the context of the couple's work. The couple should also be included in the triangular interview, and the therapists' ideas about the efficacy of psychotherapy and pharmacotherapy spelled out. The danger of seeing one member of a couple initially involves confidentiality. For example:

A couple had been in psychotherapy with a counselor for approximately four months. During this time, the wife had become increasingly withdrawn. Her husband reported that she seemed distracted and depressed, and wasn't "her old self." She was referred to a pharmacotherapist for evaluation of depression. She started this session by telling the pharmacotherapist that she was feeling fine, and that she was having an affair. This affair was unknown to her husband, and she did not want him told. The pharmacotherapist now knew more than he wanted to about the couple's relationship, especially without any clear and agreed upon means of transmitting this information to the other therapist.

Table 3. Sources of Referral to Psychologists of Patients Seen Jointly in Psychotherapy and Pharmacotherapy

	Percentage
Same agency	21
Same building	16
Share office	11
Same network	9
Friends	26
Spouse	0
Previous referrals	72

Triangular contracts are also influenced by timing, ie, when in the course of the patient's overall treatment they are set up. One variable is the therapists' familiarity with each other. As therapists become more comfortable and knowledgeable about one another, triangular arrangements seem to be initiated earlier in treatment. The referring therapist develops a quicker sense that his/her col-league will be useful, and initiates the process. The further along in time a patient is in one mode of therapy, the potentially more complex is the addition of a second therapist, especially when the first therapist feels stuck or frustrated. Referral for consultation may offer an effective way out of troubled waters, but also may seem to be a withdrawal or rejection. Sometimes the request for a consultation does mean more than a request for a treatment triangle. Instead it may be a latent request to transfer an undesirable patient.

Table 4. Referral Resources for Pharmacotherapy for Psychologists Who See Patients Seen Jointly

	Percentage
Same agency	23
Same building	10
Same office	12
Same network	7
Friends	21
Spouse	1
Previous referrals	66

Sometimes the referring therapist may be asking for psychotherapy supervision, not medications.

The triangular relationship requires openness, trust, the ability to diplomatically contact a colleague on a puzzling treatment decision, and to tolerate being questioned about one's own treatment decision. Given the complexities of this triangular relationship, it is not surprising that the most common referral sources are friends and those with whom previous referral relationships have been successful (Tables 3 and 4). A number of respondents to our survey questionnaires indicated that when they have experienced difficulties with a referral source or resource they simply faded their professional relationship with that individual. Therapists (psycho- or pharmaco-) who are indirect, unprofessional, or selfish will find themselves involved in fewer and fewer therapeutic triangles.

Our findings indicate that collaborative arrangements between psychotherapists and pharmacotherapists are common and for the most part, work well. These arrangements should be viewed as unique opportunities to enhance compliance to therapeutic plans rather than situations in which patients are likely to sabotage both treatments.

ACKNOWLEDGMENT

This work was supported in part by a Biomedical Research Support Grant #61-2837, University of Washington. Computational assistance was provided by CLINFO computer systems funded under General Clerical Research Center Grant #RR-37.

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