For patients with psychiatric illnesses, the treatment team today often consists of a psychotherapist, psychiatrist, and/or primary care physician—all of whom are motivated to achieve the same goals. These include full remission of symptoms; improvement and restoration of function, quality of life, and relationships; and the delay and preferably prevention of recurrence of symptoms. As a result of a variety of medical and socioeconomic factors, cotreatment is becoming the rule rather than the exception. The patient receives psychotherapy from a psychotherapist while receiving medication from a psychiatrist or primary care physician. Some psychiatrists embrace this model, while others vehemently oppose it.

**Pitfalls and benefits of cotreatment**

Cotreatment has potential dangers. These include inappropriate prescribing of medication without the physician's full knowledge of the patient's history (because the patient has been seen for only brief periods of time). The psychotherapist and psychiatrist may give discrepant information to the patient, creating confusion and misalliance. Splitting by the patient may occur. Unclear issues of confidentiality may occur, with associated clouded clinical and legal responsibility concerning who is responsible to the patient in times of emergencies and with whom the ultimate decision making rests when disagreements occur between the therapist and physician. Finally, reimbursement conflicts can occur if the patient has limited sessions authorized by the managed care company.

However, there are also many potential benefits of cotreatment. Psychiatrists, psychologists, and other psychotherapists bring to the treatment team different experiences, education, and approaches. Use of the special talents of each person on the treatment team can be of significant benefit to the patient. While controversial in some situations, use of a cotreatment model may represent a more cost-effective use of resources. There may be the opportunity for the patient to choose a therapist of similar ethnic background and gender if desired; this is especially beneficial if a psychiatrist/physician of that ethnic background or gender is not available in that location. There can be an increase in time and resources made available to the patient. Finally, cotreatment allows for support between the psychotherapist and the psychiatrist or other physician, which is especially important when dealing with complicated, difficult, challenging, and problematic cases.

Regardless of your opinion of cotreatment, this will likely be the continuing model, at least for the foreseeable future. In this article, I will discuss several keys to successful cotreatment.

**Understanding the benefits**

The first key is to understand the benefits of combining psychotherapy and pharmacotherapy. A number of studies have demonstrated that the combination of psychotherapy—for example, cognitive psychotherapy—and pharmacotherapy is more effective than either modality alone. A meta-analysis by Friedman and...
associated1 of 5 studies involving 685 patients demonstrated that rates of remission with the combination of cognitive therapy and medication were significantly higher than rates of remission with medication only.

The largest study included in this meta-analysis was that by Keller and colleagues2 that compared a cognitive behavioral-analysis system of psychotherapy versus nefazodone versus the combination in patients with chronic depression. The investigators found the combination to be clearly statistically superior to either of the individual treatments in this difficult and challenging group of patients. There is evidence that psychotherapy decreases relapse rates following incomplete remission of depression,3 that it attenuates panic attacks during discontinuation of benzodiazepines,4 and that it is more effective in combination with drug therapy (than drug therapy alone) in the treatment of panic disorder5 and social anxiety disorder.6

All psychiatric disease is recognized to be a result of biopsychosocial factors. It is consequently to be expected that biologic and psychosocial treatments are effective in the treatment of psychiatric disease, with the combination being most effective. These modalities operate through different mechanisms but achieve the same end point, as has been highlighted by single photon emission CT and positron emission tomography studies that demonstrate changes in the brain from psychotherapy.7-9

Voicemail, e-mail, snail mail, just mail
Successful cotreatment begins even before the patient is seen by the cotreater. It is essential that communication occur. The exact means of communication is less important. A major issue that needs to be discussed is the specific reason for the referral. Often psychiatrists do not fully understand the reason for referral from psychotherapists and vice versa. It is important for the person making the referral to provide a diagnostic impression; discuss issues of danger, including suicidal or homicidal ideation; and reveal a known or suspected alcohol or drug abuse problem. All of these issues will impact the strategies used by the cotreater.

An important and often unrecognized need at the time of referral is information regarding the patient's acceptance of and motivation for referral, which I will discuss later in this article. The presence of an Axis II disorder can dramatically affect the establishment of a therapeutic relationship, as well as strategies used during the interview and during treatment. A history of abuse, neglect, and/or victimization similarly affects the establishment of the therapeutic relationship.

It is important, finally, to discuss how emergencies will be handled, especially during vacations or when one caregiver is unavailable.

Patient perceptions of referral and of the physician
Referral for psychiatric consultation has various meanings to various patients. The referral may be seen as an opportunity to have a diagnosis of an illness validated; that is, it allows the patient to recognize that he or she is suffering from a biopsychosocial disorder rather than a perceived characterologic flaw or weakness. The patient may, however, take the referral as a rejection by the psychotherapist or an indication that the psychotherapist believes the patient is "too ill" for the psychotherapist to treat. It may be interpreted as a lack of confidence by the psychotherapist in the patient's ability to use psychotherapy to make necessary changes. An understanding of these dynamics facilitates the psychiatrist/physician in intervening to identify, challenge, and correct these distortions and assist in preserving the therapeutic relationship with both caregivers.

Successful treatment involves careful attention to the therapeutic alliance and to issues of transference and countertransference. Patients may see the physician as an authority, a controlling individual, a healer, or a judge and react accordingly. On the other hand, the physician may be seen as caring, nurturing, and gratifying. Individuals with dependent personality disorders may experience this as threatening and consequently develop a reaction formation with counterdependence and rejection. The physician may be perceived as a directive healer and instructor. This may be gratifying to some patients, while others may see it as an attempt by the psychiatrist/physician to control or manipulate the patient; thus, it may engender reactions of rage, defiance, or passivity. An understanding of the dynamics of the
Keys to Successful Cotreatment

treatment encounter allows the physician to react in a way that encourages the development of a therapeutic alliance and increases the likelihood that the patient will remain in treatment and adhere to the agreed-upon treatment protocol, including the use of appropriate medications.

Splitting and triangulation

In the cotreatment model, there is a triangular relationship, with the multiple perturbations, interruptions, and obvious or subtle collusions and disruptions that this can produce. Splitting within the cotreatment model can present in many different ways. The psychotherapist who referred the patient to the physician may be seen as rejecting, while the physician accepting the referral is seen as caring, or vice versa. The psychotherapist may be seen as incompetent because he is unable to prescribe medications to the patient and generally does not have training as extensive as that of the physician, who is seen as competent. The physician may be seen as accepting, especially if the interaction between the physician and patient revolves solely around medication issues, while the psychotherapist is seen as pressuring, especially if the psychotherapist is challenging the person to change preexisting, unsuccessful coping strategies or using cognitive or dynamic techniques.

On the other hand, the physician may be seen as cold and technical, being solely interested in the medications the patient is taking, while the psychotherapist is seen as warm and humanistic, being interested in the patient as a person. The physician may be seen as controlling, while the psychotherapist is seen as supportive.

Splitting not only occurs between different members of the treatment team, but it can actually occur in the patient's mind between the physician and the medication. The physician may be idealized and the medication devalued, leading to nonadherence to the medication regimen. Conversely, the medication may be idealized and the physician devalued and seen simply as a prescription writer, a "provider" in managed care terminology, who can easily be replaced by any other provider who has a prescription pad.

Triangulation can also occur. The third party entering into a therapeutic relationship can be a stabilizing and beneficial influence or can be seen as a threat. Oedipal issues can arise in the patient or therapists, producing competitiveness, fear, anger, and rage. Projection and splitting by patients can lead to competition between the psychotherapist and physician. Patients often have fantasies about physician and psychotherapist communication. These are often eased by having the cotreaters communicate while the patient is present (eg, during phone calls).

The meaning of medication

As indicated earlier, the goals of treatment include remission of symptoms; improvement and restoration of function, quality of life, and relationships; and delay and/or prevention of recurrence of symptoms. To achieve these goals, the patient must adhere to and remain in treatment. There are many reasons for which patients discontinue treatment, and unfortunately, studies indicate that the majority of patients discontinue psychotropic medications within the first few months of their being prescribed—well before discontinuation should occur. Consequently, successful cotreatment involves the energetic and constant vigilance of all members of the treatment team to ensure the patient's use of medications and medication adherence.

An understanding of the meaning of the medication to the patient can alert the cotreaters and signal that nonadherence is likely to occur, consequently providing an opportunity for an appropriate intervention. It is essential that all members of the treatment team intervene when nonadherence occurs and not simply leave it to the prescribing physician. Patients may have unrealistic expectations of magical cures by medications, and if such cures do not happen immediately, discontinuation of the medication becomes a likely event. Patients may believe that taking a medication absolves them of personal responsibility for their own progress, growth, and recovery. They may be fearful of medication because they fear addiction; sedation; loss of control; or certain side effects, such as sexual side effects and weight gain. Alter natively, the medication may be seen as a "gift" from the physician, especially if samples are provided.

Side effects also have various meanings to patients. They may see the physician as inadequate if side effects develop. They may believe the physician has violated their
trust or is punishing them, which may precipitate frustration, anger, and discontinuation of treatment. On the other hand, the patient may interpret side effects as evidence that he is hopeless and inadequate or that treatment has failed.

**Managed care issues**

Managed care issues also must be considered when constructing the shared treatment plan. One significant concern is the "dumping phenomenon." This occurs when the patient has exhausted his coverage for psychotherapy visits, but continues to require medication treatment. If the patient subsequently experiences a crisis as a result of a stressful life event, the psychiatrist/physician may feel "dumped on" when the patient calls the psychiatrist for help, because the psychiatrist expects the psychotherapist to be the individual best able to handle this situation. Patients and therapists must remember that the end of managed care coverage does not necessarily mean the end of treatment. This, as well as the cost of possibly continuing treatment after the end of covered visits, should be discussed with the patient and by members of the treatment team. Similar situations occur when patients change insurance coverage or caregivers change accepted insurance coverage. Splitting, with idealization and devaluing, plus conscious or unconscious sabotage of the treatment team by the patient, therapist, or physician can occur in these situations.

**Conclusions**

Cotreatment can not only be successful, it can offer the patient synergistic benefits beyond those offered by the physician or psychotherapist individually. With mutual respect, close communication and cooperation, and formulation of an appropriate treatment plan that includes a plan for emergencies and challenging circumstances, physicians, therapists, and patients can successfully negotiate the potential dangers and pitfalls of the cotreatment model and benefit from its advantages.

It is essential that all members of the treatment team see each other as colleagues and not competitors and that lines of communication be maintained in a collaborative fashion. Challenging circumstances must be anticipated and addressed, including the results of triangulation with splitting, idealization, devaluing, and premature treatment discontinuation. An understanding of the psychodynamics of referral, consultation, and medication and an appreciation of the manner in which physicians and therapists are seen by patients will facilitate successful treatment and the furthering of the therapeutic alliance. While cotreatment is fraught with many dangers, these are more than compensated for by its benefits to all members of the treatment team. Careful attention to the key points outlined above can help resolve any issues or conflicts that arise and keep the patient on his planned course for recovery, remission, and functional restoration.

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**Drug Mentioned in this Article**

Nefazodone (Serzone)

**References**


