PSYCHOTERAPIA 3 (190) 2019
pages: 17–28
DOI: 10.12740/PT/113336

Władysław Sterna[1], Sławomir Murawiec[2]

COOPERATION OF A PSYCHIATRIST AND A PSYCHOTHERAPIST — PRACTICAL ISSUES

[1] Katedra Psychiatrii Collegium Medicum Uniwersytet Zielonogórski

[2] Specjalistyczna Praktyka Lekarska

psychotherapy
cooperation in treatment
split treatment

Summary

Combining psychotherapy and pharmacotherapy concerns at least 1/3 of people being in contact with psychiatrists and psychotherapists. Helping is effective when it is possible to establish a triadic therapeutic alliance involving the patient, the psychiatrist, and the psychotherapist. Cooperation in such a team requires additional skills from clinicians. At the stage of considering the possibility of cooperation, clinicians should contact each other to determine the possibilities and terms of it. Communication between specialists should take place from the beginning of treatment. It is important for specialists to share at least such information as prolonged absence of any of them, change in the therapeutic approach, significant changes in the clinical condition, or the overall impression about the patient's response to treatment. There are also situations in which it is not possible to establish cooperation which would be satisfactory for all the specialists. In this article, the authors discuss the most important principles of good cooperation between a psychiatrist and a psychotherapist and point out the factors that promote it. These can be the starting point for creating recommendations regarding good practices in this field and initiate a discussion within the professional environment on this subject.

Introduction

The situation in which a person in the course of psychotherapy at the same time takes psychotropic drugs is not uncommon. There was a research conducted in Poland in 2015 involving psychotherapists working in Warsaw, which assessed the scale of combining these two treatments: psychotherapy and medication use. In the first study involving 36 psychotherapists who treated 281 patients, as many as 55% of the patients simultaneously took medication during psychotherapy [1]. Interestingly, it was found that a greater number of patients being in cognitive behavioral therapy (CBT) take medications (68%) than in therapies with psychoanalytical and psychodynamic modality (47%). This preliminary study was conducted in a medical center where the number of psychiatrists and psychotherapists is about equal.

In another study, carried out in a psychotherapy clinic, data were obtained from 545 patients treated psychotherapeutically by 63 psychotherapists with psychoanalytic and psychodynamic orientation. In this group, 33% of patients took medicines at the same time (while taking part in

psychotherapy) [2]. This result was lower than the previous one and allowed to estimate that approximately one-third to one-half of the patients participating in psychotherapy simultaneously take psychiatric drugs. The survey held on the participants of the conference ”Psychiatrists for Psychologists 2015” organized by the Therapy Center “Dialog” in Warsaw obtained data including 671 psychotherapeutic processes, 45% of which were combined with pharmacotherapy. According to the previous results, in the case of cognitive-behavioral psychotherapy, the percentage of combining was higher and was estimated at 50%, while in the case of psychoanalytical and psychodynamic psychotherapy, 41% of patients used combined psychotherapy [unpublished data].

To sum up, it can be said that at least 1/3 of patients participating in psychotherapy simultaneously take psychotropic drugs, although even higher values, between 40-50%, may be closer to the truth. Research results indicate that many people involved in psychotherapy at the same time take also drugs, and experts see the benefits of such combined treatment [3, 4].

Integrated and split treatment

The use of drugs during psychotherapy can be carried out in an integrated or divided manner. In the integrated version, one clinician provides both psychotherapy and pharmacotherapy – in Poland, this is done by a psychiatrist. In the split treatment, one clinician carries out psychotherapy, and the second pharmacotherapy. Despite the widespread use of this approach, there are astonishingly few publications concerning this topic in the Polish language. One paper published in 2016 [5] reviews the pros and cons of combining psychotherapy and pharmacotherapy.

The combining of psychotherapy and pharmacotherapy is rarely discussed, although recent studies [3, 4] indicate that there is a high level of acceptance of psychotherapy as a treatment method among psychiatrists. Therefore, this could imply a wider discussion and experience exchange within the specialist community. However, no recommendations have been created in Poland regarding the cooperation of psychiatrists and psychotherapists despite the fact that they have been present in the world for a long time and are being systematically supplemented [6].

Split treatment paradoxically requires from clinicians higher competence than leading psychotherapy alone or combined treatment. Split treatment requires from those, who are involved in it, to recognize a phenomenon, which Busch and Gould [7] call ”therapeutic triangle” and to obtain what Kahn [8] described as ”triadic therapeutic alliance.”

Ethical issues are also important in the issue raised in this work. When split treatment is applied according to indications related to the patient (e.g. diagnosis), ethical problems do not concern the legitimacy of choosing such a solution. In a situation where split treatment follows a trend towards cost reduction, ethical problems appear very often [9].

Beginning of cooperation

Given the clinical problem and the resources of the patient, it would seem that it is their personal qualities and the type of problem with which he/she faces, which should decide on the form of the help granted. Meanwhile, very often there are other factors that decide that the patient first comes to a psychiatrist or a psychotherapist – at least because of the availability of various groups of specialists. If the patient meets a psychotherapist first among the available or selected clinicians, it is this person who often decides whether the patient will undergo further evaluation by a psychiatrist in order to evaluate the necessity of implementing drugs. If the first specialist to be contacted by the patient is a psychiatrist, he or she may also have psychotherapeutic education. In such a case it will depend on him/her whether he/she will also provide the patient with psychotherapy or refer to another clinician for psychotherapy. The results of a study indicate that if a psychiatrist-psychotherapist does not take up psychotherapy himself/herself, he/she more willingly gives the recommendation for psychotherapy [4] than if he/she is not a therapist. It is the "first contact" clinician, who often will have the responsibility of managing the process and methods of help given.

Patients' preferences as to the methods of given help and commitment of one or two relationships with specialists may vary. Some patients may prefer exclusive relationships, *i.e*. the convenience and privacy when dealing with one clinician. Such patients may refuse suggestions of including a second specialist in the treatment process. Other patients appreciate the opportunity to use the complementary skills of two clinicians and want to take advantage of a wider range of help. Some psychopharmacotherapists appreciate the opportunity to specialize only in the branch of medicine and build a database of recommended psychotherapists, while others do not decide to narrow their scope of help. Some psychotherapists are pleased widening the helping offer by including a psychiatrist into cooperation. Others do not like the loss of autonomy by opening an intimate, dyadic relationship with a patient to cooperate with a new clinician. As for the patient and both clinicians, cooperation can alleviate stress associated with the feeling of the sole responsibility for the treatment. However, such cooperation is more complicated and generates higher costs, which are practically not reimbursed [10].

In the case of establishing cooperation, it is necessary to define it. Generally, situations of this kind may arise in three forms: consultation, supervision, and cooperation [11]. Consultations take place between two professionals, one of whom asks the other for consultation. The clinician considers the consultant's recommendations and decides whether to follow them or not, taking into consideration the knowledge of the patient and his/her understanding. Consultations may take place in a formal or informal manner. In the formal way, the consultant usually reads the patient's documentation and/or meets the patient. The conclusions of the consultation are written down in the patient's documents. During the informal consultation, the patient's identity is not disclosed, and

the clinician should obtain the consultant's possible agreement to write his name in the documentation. An example of informal consultation will be the conversation of two clinicians on the occasion of a scientific conference, *e.g.* between a participant and the lecturer.

Supervision is a way of cooperation in which a supervisee is generally obliged to follow the supervisor's recommendations. Supervision may be close at the beginning of the cooperation and then may change as the supervisee becomes more experienced. Cooperation is based on constant sharing of responsibility in simultaneous direct patient care and is often initiated during a consultation request.

Drug introduction

If it is the psychotherapist's initiative to introduce drugs, the patient should be given an explanation concerning the understanding of the pharmacology effects and time for the patient to reveal their feelings and expressions. Applying pressure to a patient may result in a negative reaction and thus eliminate the potentially positive effects of the drug. Although they are obvious, the non-pharmacological aspects of psychotropic drug effects are rarely discussed with the patient [12]. When carrying out pharmacological treatment, it is worth considering the fact that the transference phenomenon may also apply to the drug. In such a situation, this will be expressed through complaints about the side effects, which are in fact "pseudo-side-effects," and therefore are not the result of biological drug qualities, but widely understood feelings and interpretations, which the patient is experiencing and creating.

Careful use of medicines

The prescribing psychiatrist must consider the context in which he/she prescribes the medicine and the potential non-pharmacological aspects of drug effects [12]. Some patients will require building a particularly strong therapeutic alliance before they will be able to take the medication. People who are distrustful or doubt in drug effectiveness first have to gain the feeling of confidence in the psychiatrist's competence and his/her ability to take care before they will be able to accept the prescription. The use of drugs during psychotherapy may negatively influence the therapeutic relationship through its pharmacological effects [13]. Antidepressants can trigger mania/hypomania occurrence among individuals classified into the bipolar spectrum. The use of neuroleptics may cause sedation or depression. Side effects of tricyclic antidepressants can destroy the therapeutic alliance. Patients who are paranoid can interpret the drug's side effects as a manifestation of the psychopharmacotherapist's hostility. Too rapid symptomatic improvement may effect in loss of motivation for personal change and a quick return to the previous, non-adaptive pattern of functioning. Also the patient's relatives, noticing rapid symptomatic improvement, may encourage the patient to discontinue therapy as an unnecessary effort.

Cooperation

Most specialists believe that close communication and contact between a psychopharmacologist and a psychotherapist is essential. Busch and Malin [14] discussing this problem indicate that there are some analysts who try to have as little contact with the pharmacotherapist as possible to maintain neutrality, which supports the therapeutic process. In this model, the analyst limits communication with the consulting psychopharmacologist and explores pharmacological therapy just like any other process in the patient's life. In modern recommendations, this approach is extremely rare.

Despite the cooperation is highly recommended, the implementation of this advice is not obvious. According to some studies [15], the co-ordination rate of treatment on the part of psychiatrists and psychotherapists varies within very wide limits from 0% to 100%, but only 36% of psychiatrists always coordinate split treatment. Another study indicates that in at least 1/4 of treatment processes provided by two specialists, lasting over half a year, there was no communication between the therapists [16]. It is characteristic that representatives of both professional groups believe that they are the ones who initiate contact more often [17]. The cooperation between the two clinicians is based on a set of skills other than standard diagnostic and therapeutic skills, and many clinicians have not been trained in this. At the stage of assessing the possibilities of cooperation, it is worth asking oneself the following questions [18]:

1. How do you communicate? Personally, by phone, or email? How often will you contact one another? What information will be shared? Will there be events other than routine contacts that may cause contact (*e.g.* absence of the patient, change of medication).
2. Have you agreed on your roles and the way they will be implemented? [For example, if the therapist notices a negative reaction to the introduced drug, he/she should be prepared to contact the psychiatrist. The psychiatrist should warn the psychotherapist about the expected side effects, as the therapist has more frequent contact with the patient.]
3. Is there a mutual understanding of the patient's current condition? Are there any signals suggesting a worsening of the patient's condition that both of you should pay attention to?
4. How do you deal with potential conflicts? [It is not uncommon for patients to attempt to antagonize clinicians by providing them with conflicting or incomplete information, which may result in different treatment concepts.]

Factors favoring and hindering cooperation are numerous and relate to various categories. Developing working relationships between clinicians takes time. It often starts with working with one common patient and develops as their number increases. Difficult patients are catalysts of the intensity of cooperation and most clinicians feel relief having an opportunity to share the burden of care [19]. Expecting both clinicians to have the same goals from the beginning is unrealistic. Short-

term goals can be different as long as they are not mutually exclusive. The same applies to different paradigms of conceptualizing the patient's problems. The colocation of the specialists' offices is conducive to cooperation, as it allows to contact frequently, even if such meetings are short-lasting. The disadvantages of this solution mainly focus on the issue of autonomy, because some specialists strongly prefer it.

Establishing a therapeutic triangle takes place very early, already at the level of referral to the therapy process. The patient may perceive a suggestion of additional treatment as passing him/her to another person or recognizing him/her as a "hopeless case." The pharmacotherapist can be idealized as a good object, which may harmonize with unrecognized collusion with the patient – based on the subconscious message that the psychiatrist can deal with the problem himself/herself. Therefore, the role of the psychotherapist should from the beginning be clearly defined basing on an open and respectful relationship with the psychopharmacologist. Mutual contact, especially at the beginning of the treatment, can reduce the risk of the dissociation of the patient who brings different content into meetings with a psychiatrist and a psychotherapist [20]. Because the psychotherapist meets with the patient in the split treatment much more often, he or she should receive information from the psychopharmacologist about possible symptoms and side effects of the pharmacological treatment.

Among the competencies of clinicians that favor cooperation in split treatment, particularly respect and openness to cooperation are emphasized [10]. In such a manner a "team" is a collaboration of two clinicians built for practical purposes, related to the treatment of one or more patients. The challenge, but also a practical skill, will be to identify those clinicians with whom work will be too difficult or impossible due to basic differences in clinical values, treatment programs, personality styles, or competencies.

Interdisciplinary and organizational processes also take place in the cooperation between the psychopharmacologist and the psychotherapist. Cohen [21] writes about the jealousy of the analyst (psychotherapist) towards the psychopharmacotherapist who does not have to endure the pain of analysis and sees the patient briefly while waiting for the drug to work. Psychiatrists, in turn, may consciously or not, be jealous of the freedom of the relationship that psychotherapists have as well as the fact that it is not so much constrained by the laws or treatment algorithms. Such jealousy takes place not only between individuals but also between professions in general.

The term "integration" is often used in the literature in the context of psychotherapy and pharmacotherapy taking place in one organizational structure. In fact, however, institutions often create a defense against integration by sharing tasks to meet the patients' needs. And so, despite working for the "bio-psycho-social" model of helping, in essence, psychiatrists deal with "bio", psychotherapists – "psycho" and social workers deal with "social" aspects of the clients' problems. In this sense, the declared integration does not actually occur [22].

Among the conditions for the proper split treatment conduction, the authors mention the necessity to know the experience, qualifications, area of specialization, theoretical formation, and the type of patients that each of the professionals would not like to treat [23]. Obtaining the patient's informed consent is an essential condition to communicate with another specialist. Most patients are satisfied knowing that professionals communicate with each other. Patients rarely disagree with the cooperation between a psychotherapist and a psychopharmacotherapist. A patient's refusal of communication between professionals prevents the correct development of split treatment and is therefore not recommended to be conducted in such a situation [10].

It is very difficult to establish and maintain the boundaries of psychopharmacotherapeutic interventions. On the one hand, Ellison [10] suggests that a psychiatrist should avoid making deep interpretations, delving into very personal areas such as the history of trauma; refrain themselves from excessive availability as an empathetic listener, which can encourage patients to expect continuous gratification. This leads in fact to the idealization of the pharmacotherapist and interferes with the alliance between the patient and the psychotherapist. Similarly, even a psychotherapist who is familiar with the drug's specifications, should maintain awareness not to advise the patient on the choice of the drug and dosage and not to discuss side-effects. Therefore, if a patient undertakes the subject of a drug's side effects in a conversation with the psychotherapist because he/she is embarrassed by their nature (*e.g.* sexual dysfunction), he/she should be encouraged to discuss these problems with his/her psychopharmacotherapist. Likewise, if the patient informs the psychopharmacotherapist about such problems as drug use or painful feelings of transference, he/she should be encouraged to talk about these problems with the psychotherapist. On the other hand, Goin [24] claims that after getting acquainted with the patient, the psychodynamic interpretation of resistance and defense may be useful.

In order to organize the rules of cooperation between clinicians in split treatment, the authors [25] have established seven principles of good cooperation:

1. Clarity of relationship (cooperation or supervision) and establishing what are the tasks of each clinician.
2. Contract. A written agreement about responsibilities and roles will help to dispel the assumption that the psychiatrist oversees the entire process of helping.
3. Communication that occurs routinely between clinicians, even when the treatment is going well.
4. The patient's aware consent, which requires the patient to know and understand the role of each clinician within his/her treatment process.
5. A comprehensive review of what happened in therapy, especially if the psychiatrist meets the patient quite rarely.
6. If clinicians don't know each other well, they should gather important information about each other.

7. External consultations, which should be sought when problems arise concerning the course of treatment or compliance with the principles of cooperation.

The recommendations discussed above regarding cooperation between professionals providing combined treatment seem to be a good reference point. The minimum level of communication does not need to be met in such moments of the helping process as starting and ending treatment; change of the treatment plan; possible problems; absence of one clinician [26].

In split treatment, there are areas that overlap, such as monitoring suicidal tendencies. Each of the clinicians should support the other's position concerning various issues, for instance when the psychotherapist asks the patient whether he/she takes medications as prescribed or when the psychiatrist asks about the general course of therapy. The authors [27] give examples of such constructive dialogues. A specific situation occurs in the case of couple therapy when it turns out that one of the partners requires pharmacological help. In order not to invalidate the potential of one of the couple: "yes, I see that it is not me who has a problem, I do not need medication," the authors suggest that the first consultation with a psychopharmacotherapist should take place with the couple.

Problem-solving

It is common that in any kind of cooperation, problems may occur [26]. Psychopharmacologists report several typical problems during collaboration. According to some psychopharmacotherapists, psychotherapists expect an excessive amount of details about the patient, which do not necessarily relate to current treatment. The therapist may want to describe the patient's past traumas in detail, while the psychopharmacologist needs to know just about recent changes in symptoms that help him/her to assess the need for change in treatment. Some therapists directly suggest patients that they should take a specific drug, which psychiatrists feel as a manifestation of encroachment on their competences. Finally, according to psychiatrists, many therapists are not available when urgent contact is needed. On the other hand, therapists also have some objections about cooperation. From their perspective, psychiatrists do not reciprocate, *e.g.* when the therapist provides important information to the psychiatrist, and he/she does not respond to the contact, despite a recent significant change in treatment. According to therapists, psychiatrists do not always report important events, such as the fact that a patient has been hospitalized. Sometimes, the psychiatrist recommends a different therapy modality than the one the therapist uses without consulting him. Finally, both professionals may have different opinions on what constitutes evidence-based practice (EBM).

To be effective, both clinicians should be able to provide information and exchange experiences, which would prevent patients from dividing information given to the clinicians. If

needed, it would be possible to initiate a meeting of the patient, the psychiatrist and the psychotherapist in order to find a therapeutic solution and ensure the safety of the clinicians [24].

Even when collaborating clinicians are open to collaboration, combined treatment may fail when there are significant ideological differences in the perception of the patient or the treatment; mismatches between the clinicians' work styles; poor communication; doubts about actual competences, or ethics [10]. A very pragmatic reason for breaking cooperation may be the lack of time for mutual communication. The reason may also be cooperation below standards of practice when, for example, the therapist frequently cancels sessions or the psychopharmacologist recommends outdated or ineffective drugs [28].

There is no other situation in which mutual communication between clinicians is as important as in conflict situations. When the patient describes the incorrect, in his opinion, behavior of the other clinician, one should be extremely cautious, as long as such behavior has not been adequately examined and verified. Sometimes a short conversation between the clinicians may explain a simple misunderstanding or the error behind it [10]. If the conflict is more serious, it may be helpful to consult with a mutually acceptable external consultant. In the case of a major violation of ethical rules, the clinician may face a serious dilemma. In this situation, it is good to consult an experienced colleague or seek legal advice. Interrupting combined treatment is a very negative experience for the patient. However, indelible objections to the cooperating clinician may lead, after consultation, to resign from joint treatment, as otherwise it might cause harm to the patient and an unacceptable risk to the clinician.

A psychiatrist who conducts pharmacological treatment in a difficult situation cannot stop treatment at any time and in any way. As the psychotherapist can not provide pharmacological treatment, the argument that after stopping medication the patient is still being treated, is not justified. In particular, the end of treatment in a crisis situation, the lack of recommendation for alternative care – may be the reason to assess this action as abandonment and, as a result, is considered medical malpractice [29]. The termination of cooperation must be made within a reasonable time in advance, which generally means 30-60 days so that the therapist and the patient can establish effective cooperation with another pharmacotherapist.

In teamwork, although it improves the quality of patient care, there are three potential conflict areas [30]. Role diffusion is an ambiguity where the duties and knowledge of one clinician end in relation to other professionals. Competition between representatives of various disciplines causes polarization between the medical and therapeutic paradigm, and so impede integration. Actual or experienced inconsistency between laying out the responsibilities and division of power is a fairly common experience of team members. The above-mentioned authors also point out that legal ambiguity regarding cooperation may be problematic, which can be interpreted in several ways: 1) as a partnership (then specialists can be mutually responsible for the actions of the other);

2) subordination (when one is responsible for the actions of the other); 3) team (when no legal rules have been established); 4) separate practices (each is responsible for his own actions). It is necessary to determine what form of cooperation is dealt with.

Recommendations

The authors [22, 24, 31] issue the following recommendations regarding the prevention of problems in split treatment:

- if both clinicians have not known each other so far, it is worth getting in contact, *e.g.* by phone, which would replace the idea of the second clinician with real information;
- it is worth knowing the specific expectations of the second clinician and his/her preferences: whether he/she expects preliminary information about the patient before meeting him or her or if he/she wants to consult only after such a visit;
- it is worth to talk with a clinician about clinical cases and to get to know the way he/she conceptualizes clinical problems;
- recognition, whether a referral for a consultation hides additional motivations (gratitude for previous cooperation, preparation of recommendations for the future, the result of mutual friendship, etc.) may be helpful.
- professional respect for the clinician you work with;
- constant attention to the manifestations of transference and countertransference;
- if the therapist is not familiar with the drug specifications, the pharmacotherapist should explain its effect, duration of use, possible side effects, interactions with other drugs. If the therapist stays conscious with the pros and cons of the drug, he/she would be more aware of possible complications connected with drug use;
- obtaining the patient's informed consent to the cooperation of the clinicians and clarifying the nature of their contacts;
- when clinicians have great respect and openly communicate with each other, triangular transference can be predicted and understood, and the triangular countertransference may be recognized without embarrassment and negative impact on treatment;
- when a patient wants to quit psychotherapy in order to stay in pharmacotherapy, the psychiatrist may offer treatment provided under the condition that the patient stays in psychotherapy so as not to depreciate it;
- as far as the patient pays for the consultation of the clinicians, he/she should be sufficiently informed about the importance of such consultations and how they affect the quality of the help provided. However, clinicians cannot wait for the costs to be approved before initiating cooperation, as this expectation is harmful and potentially dangerous;

- cooperation between clinicians most often breaks down due to the lack of time and structures facilitating communication, confidentiality issues, different languages in describing the patient, and working style – so these are areas needing particular attention;
- regardless of the stage of psychotherapy, when drug therapy may be initiated, the therapist should explain his/her reason for the pharmacological recommendation allowing the patient to consider this problem.

Recapitulation

According to the actual state of knowledge about the treatment of mental disorders, the question of whether to join psychotherapy and pharmacotherapy seems to be out of date. It is better to raise a question about circumstances, conditions, and the way of combining these two paradigms so that the patient benefits most. In this article, the authors dealt with split treatment, in which the psychotherapist conducts therapy and the psychiatrist provides pharmacotherapy. Although this approach is very common, there are few publications on this subject, especially in Polish. The aim of the publication was to present contemporary knowledge about the cooperation of a psychiatrist and a psychotherapist in the process of helping, and to initiate discussions on this topic. The next step will be to develop recommendations for cooperation.

References

1. Murawiec S, Jabłoński M, Sosnowska K, Datka W, Król-Kuczkowska A, Moraczewska A. Nastawienia psychoterapeutek do leczenia farmakologicznego w trakcie prowadzenia psychoterapii – badanie pilotażowe w wielkomiejskim ośrodku psychiatryczno-psychoterapeutycznym. Psychiatria. 2015; 12: 150-159.
2. Murawiec S, Sosnowska K, Król-Kuczkowska A, Moraczewska R. Attitudes of psychotherapists in medically-oriented and psychotherapeutically-oriented center towards pharmacotherapy in the course of psychotherapy. European Neuropsychopharmacology. 2015; 25 (suppl.2) Abstracts 28th ECNP Congress: S364.
3. Murawiec S, Kudlik A, Matuszczyk M, Sosnowska K, Moraczewska R, Król-Kuczkowska A, Bieńkowski P, Samochowiec J. Nastawienie lekarzy psychiatrów wobec psychoterapii – badanie ogólnopolskie. Psychiatria. 2017; 14: 101-115.
4. Murawiec S, Litwin DM, Seroka N, Kudlik A, Sterna W, Matuszczyk M. Nastawienie lekarzy psychiatrów wobec psychoterapii jako formy leczenia zaburzeń psychicznych - ponowne badanie w 2018 roku. Psychiatria. 2019; 16; 1; 16-25.
5. Sterna W, Sterna A. Psychoterapia i farmakoterapia - czy można je łączyć? Psychiatria 2016. 13. 2. 84-91.
6. American Psychiatric Association: Guidelines for psychiatrists in consultative, supervisory, or collaborative relationships with nonmedical therapists. Am J Psychiatry. 1980; 137:1489–1491.
7. Busch FN, Gould E. Treatment by a psychotherapist and a psychopharmacologist: transference and countertransference issues. Hospital and Community Psychiatry. 1993; 44: 772-774.
8. Kahn DA. Medication consultation and split treatment during psychotherapy. Journal of the American Academy of Psychoanalysis. 1991; 19: 84-98.
9. Lazarus JA. Ethics in split treatment. Psychiatric Annals. 2001; 31(10): 611-614.

10. Ellison JM. Teaching collaboration between pharmacotherapist and psychotherapist. Acad Psychiatry. 2005; 29(2): 195-202.
11. Sederer LI, Ellison J, Keyes C. Guidelines for prescribing psychiatrists consultative, collaborative, and supervisory relationships. Psychiatric Services. 1998; 49; 9; 1197-1202;
12. Sterna W. Niefarmakologiczne działanie leków stosowanych w psychiatrii. Psychiatria. 2018; 15(4): 220-227.
13. Beitman B. Pharmacotherapy as an Intervention during the Stages of Psychotherapy. https://psychotherapy.psychiatryonline.org/doi/abs/10.1176/appi.psychotherapy.1981.35.2.206.
14. Busch FN, Malin FD. Combining psychopharmacology, psychotherapy and psychoanalysis. Psychiatric Times 1998, 15, https://www.psychiatrictimes.com/addiction/combining-psychopharmacology-psychotherapy-and-psychoanalysis.
15. LoPiccolo CJ, Taylor CE, Clemence C, Eisdorfer C. Split Treatment. Psychiatry (Edgmont). 2005; 2(1): 43–46.
16. Baruch RL, Vishnevsky B, Kalman T. Split-Care Patients and Their Caregivers How Collaborative is Collaborative Care? J Nerv Ment Dis. 2015; 203(6): 412–417.
17. Avena J, Kalman T. Do psychotherapists speak to psychopharmacologists? A survey of practicing clinicians. J Am Acad Psychoanal Dyn Psychiatry. 2010; 38: 675-684.
18. McNary A. Managing the Suicidal Patient in a Split-treatment Relationship. Innov Clin Neurosci. 2016; 13(3-4): 42–45.
19. Lorenz AD, Mauksch LB. Models of collaboration. Prim Care. 1999; 26(2): 401-410.
20. Frey BN, Mabilde LC, Eizirik CL. The integration of psychopharmacotherapy and psychoanalytical psychotherapy: a critical review. Rev Bras Psiquiatr. 2004; 26(2): 118-123.
21. Cohen SK. The use of medication with patients in analysis: Panel of the New York Psychoanalytic Society. Journal of Clinical Psychoanalysis. 1992; 1: 26–35.
22. Konstantinidou H, Evans C. Pharmacotherapy and psychotherapy: the challenges of integrating two paradigms. Psychoanalytic Psychotherapy. 29(4): 343-362.
23. Imhof JE, Altman R, Katz JL. The relationship between psychotherapist and prescribing psychiatrist. Am J Psychother. 1998; 52(3): 261-72.
24. Goin MK. Practical Psychotherapy: Split Treatment: The Psychotherapy Role of the Prescribing Psychiatrist. https://ps.psychiatryonline.org/doi/full/10.1176/appi.ps.52.5.605.
25. Mossman D. Weston CG. Splitting treatment: How to limit liability risk when you share a patient's care. Current Psychiatry. 2010; 9(3): 43-46.
26. Tekell JL, Erickson SS, Matthews KL. Collaboration with the nonphysician therapist. Acad Psychiatry. 1997; 21(3): 155-164.
27. Chiles JA, Carlin AS, Benjamin GAH & Beitman BD. A physician, a nonmedical psychotherapist, and a patient: The pharmacotherapy-psychotherapy triangle. In: Beitman BD & Klerman GL eds. Integrating pharmacotherapy and psychotherapy (pp. 105-118). Arlington, VA, 1991, US: American Psychiatric Association.
28. Gitlin MJ, Miklowitz DJ. Split treatment: Recommendations for optimal use in the care of psychiatric patients. Annals of Clinical Psychiatry 2016. 28(2); 2-7;
29. Gutheil TG, Simon RI. Abandonment of patients in split treatment. Harvard Review of Psychiatry. 2003; 11: 175–179.
30. Gardner CS, Holzman SR. Interdisciplinary collaboration: psychiatric medical backup in the outpatient clinic. Psychiatr Q. 1983; 55(4): 253-260.
31. Pilovsky D, Bellinson J. Psychotherapist, Psychiatrist and patient. A triadic relationship. J Psychother Pract Res. 1996; 5(1): 26-34.

E-mail address: wladyslawsterna@gmail.com