Working With Psychotherapists Now Important in Psychiatry

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SAN FRANCISCO — In psychiatry, the thinking has changed on working with psychotherapists who lack supervision, according to Dr. John Q. Young, Dr. Young, a psychiatrist with the University of California, San Francisco, said knowing how to collaborate with doctorate- or masters-level psychotherapists is an increasingly important skill.

Years ago, not only was the emphasis on treatment by the medical doctor, but the physician often showed undisguised hostility to other clinicians, Dr. Young said as conference on research and treatment sponsored by the university. Some psychiatrists framed these issues in ethical terms. For example, a survey of psychiatrists in the 1980s showed that fully two-thirds believed that it was unethical to collaborate with non-MD therapists, he said.

More recent models of interactions between psychiatrists and psychotherapists emphasize relationships that are supervisory, consultative, or collaborative. In a typical collaborative scenario, the psychiatrist manages the patient’s medications while the other clinician—a psychologist, a clinical social worker, or a primary care physician—provides psychotherapy.

Other, more complex scenarios also are possible. For example, while the psychiatrist provides pharmacotherapy, one therapist might provide group dialectical-behavior therapy, another therapist might provide individual therapy, and a primary care physician or specialist might treat the patient’s chronic fibromyalgia pain.

Even the typical scenario sets up complicated triangular patterns of transference and countertransference. Still, Dr. Young offered several tips aimed at making such collaborations pleasant and therapeutically fruitful.

Dr. Young recommended establishing an informal or oral contract with the patient and the other clinician at the beginning of therapy. At the Langley Porter Psychiatric Hospital and Clinics, where Dr. Young serves as associate director of the adult psychiatry clinic, psychiatrists use a standard form called “Collaborative Treatment Plan for Patients.” This form emphasizes that there is no supervisory relationship between the psychiatrist and the therapist, and that the two will be communicating as necessary about the patient’s case.

The notice clarifies that medication-related problems or questions should go to the psychiatrist and that other concerns about treatment should go to the therapist. One step the psychiatrist can take is to telephone or meet with the psychotherapist early in the patient’s treatment, when it’s critical to discuss and agree on a diagnosis. In Dr. Young’s experience, the psychiatrist gains useful information—and the psychotherapist gains the client’s trust—prised—if the psychiatrist inquires about the therapist’s working diagnosis.

It also is helpful for the psychiatrist and psychotherapist to learn and appreciate each other’s focus. “This goes to developing ways of relating beyond our historical tribal conflicts.” Dr. Young said. Furthermore, it is in everyone’s best interests for the collaborators to understand each other’s preferences. “This is a very exciting recommendation,” said Commissioner Jack Ebel, a health policy consultant in Reston, Va. Promotion of the medical home approach is a direct way to perform the health care delivery system, he added.

Commissioners also said that the medical home recommendation reflects the Patient Charter’s support of increased pay for primary care services. An adjustment to the fee schedule is “long overdue,” said Dr. Ronald Castellanos, a commissioner and urologist in private practice in Ft. Myers, Fla. Increased pay might lure more residents into primary care, and help those currently practicing to stay in the workplace, he said.

The commissioners debated how the CMS could determine which physicians or other health providers—such as nurse practitioners—would receive the update. MedPAC staff presented the increase as budget neutral, which made some panelists uneasy.

Dr. Nicholas Wolter of the Billings (Mont.) Clinic, suggested that the increase be made without trying to maintain budget neutrality. Dr. Karen Borman, a congratulated the concept of offering primary care, Dr. Borman, who is associate professor of surgery at the University of Mississippi, Jackson, expressed concern that rewarding primary care could end up hurting other physicians.

I have some philosophical problems with this,” Dr. Borman said. I don’t believe that adding primary care was not always linked with a traditional primary care physician. I would say the public will likely become the insider standard, she said.