

28
II

**C.6 Integrating
Psychopharmacology
and Group Psychotherapy**
Norman Sussman, M.D.

INTRODUCTION

Abundant clinical and research data confirm the effectiveness of medication in the treatment of mental disorders. For some conditions—such as schizophrenia, mania, depression, panic disorder, obsessive-compulsive disorder, and insomnia—medication may be the treatment of choice. As understanding of the role of medication in treating mental disorders has improved, more effective and better-tolerated compounds have been developed. In the past two decades, the use of psychotropic medication has grown dramatically. One inevitable result of the trend toward more psychotropic drug use is the increased likelihood that patients who once would have been treated with dynamic, expressive therapies alone are being treated only with medication or with a combination of psychotherapy and medication. Indeed, as John Salvendy and Russell Joffe (1991) observed, recent advances in both pharmacotherapy and psychotherapy make an “either/or approach increasingly untenable and obsolete.”

One frequent combination of therapeutic modalities involves the use of group therapy and medication. In one survey of group psychotherapists (Stone, Rodenhauer, Markert, 1991), more than two thirds of the clinicians reported that medicated patients were included in their typical outpatient psychotherapy groups. That figure was true among all the professionals responding—physicians, psychologists, and social workers.

**INDIVIDUAL AND COMBINED
EFFECTS**

The fact that patients are treated with two disparate forms of therapy is not surprising. The approach has obvious advantages. One treatment modality may not adequately treat all the emotional symptoms, dysfunctional behaviors, and maladaptive conditions that a patient experiences; combinations of treatments may expand the spectrum of symptoms affected (Hollon, Beck, 1978).

A comparison study of antidepressants and structured intensive group psychotherapy in the treatment of bulimia nervosa (Mitchell, Pyle, Eckert, Hatsukami, Pomeroy, Zimmerman, 1990) found that the amount of improvement obtained with intensive group therapy alone was superior to that obtained with antidepressant treatment alone; however, the addition of antidepressant treatment to the intensive group psychotherapy component did not further improve the eating behavior but did result in more improvement in the symptoms of anxiety and depression.

Group therapy is generally considered most useful in developing appropriate interpersonal skills, improving self-esteem, and modifying emotional reactions. In contrast to those effects, psychopharmacology provides a reduction of disturbing symptoms, such as anxiety and depression, a normalization of psychotic or disorganized thinking, and a suppression of pathological ruminations and compulsions. For example, in panic disorder, alprazolam (Xanax) suppresses the panic attacks, and group techniques reduce phobic avoidance. Similarly, in schizophrenia, haloperidol (Haldol) suppresses hallucinations and delusions, and group therapy facilitates socialization and provides reality testing. Thus, patients treated with medication and some form of expressive, psychodynamic, behavioral, or cognitive therapy show greater improvement than do patients given medication alone. Patients who are less anxious and depressed, sleep better, are better able to concentrate, and feel more in control than in the past are more accessible to psychological interventions (Karasu, 1982).

Research and outcome studies have found that schizophrenic patients being treated with antipsychotic medication are rehospitalized less frequently than are patients receiving individual psychotherapy. The patients show greater improvement in social effectiveness and behavioral responses and decreased social inhibition when group therapy is the major treatment modality. Patients in psychotherapy groups who receive medication are the ones most likely to be anxious or depressed and least likely to be schizophrenic or manic (Stone, Rodenhauer, Markert, 1991); those patients are often seen in medication groups.

Group Therapy

The goals of group therapy whose patients receive medication differ according to whether

the group is oriented toward using insight and exploring dynamic issues or is purely a medication group. In medication groups the general goals are symptom relief, the enhancement of compliance, and the provision of support; the limited goals are the monitoring of medication, the adjustment of dosage, and the renewal of prescriptions. In psychotherapy groups in which an individual patient is coincidentally taking medication, the goals are more ambitious and more complex than in medication groups.

The limited focus of medication groups (for example, the absence of psychological-mindedness as a therapeutic element) does not preclude the involvement of group processes in treatment. Once the group is formed, therapeutic factors come into play that the group leader can either use or disregard. The more knowledgeable therapists are about group processes and the more confident they are about using group techniques, the better able they are to exploit opportunities and avoid adverse developments. One possible consequence of a patient's being in a medication-oriented group is that patients otherwise resistant to traditional group psychotherapy may accept a dynamically oriented group.

Psychopharmacology

Psychotropic drugs are traditionally divided according to their primary clinical use. Hence, drugs are classified as antipsychotics, antidepressants, antimanics, anxiolytics, and hypnotics. In fact, most drugs have more than one clinical effect and are used to treat conditions other than the one for which they are approved. Table C.6-1 lists the drugs and classes of drugs used in the treatment of major psychiatric disorders. Certain drugs used in general medical practice to treat cardiovascular disorders and seizure disorders are helpful in the treatment of mental disorders.

Because of the large number of psychotropic drugs available in each class and because the drugs are being used in increasingly sophisticated ways—both alone and in combination with other drugs—prescribing decisions can be puzzling to patients, nonphysician mental health professionals, nonpsychiatrist physicians, and even psychiatrists trained in classic psychoanalysis. At times, partial knowledge can lead to undue concern. For example, patients with panic disorder who receive a prescription for clonazepam (Klonopin), a benzodiazepine used to treat epilepsy, may

wonder if they suffer from a seizure disorder. Similarly, patients with obsessive-compulsive disorder may be treated with fluoxetine (Prozac), an antidepressant compound. Patients with social phobia may be given propranolol (Inderal), a compound used to treat cardiac disease and hypertension.

A crucial point for the prescribing physician is that the patient being medicated and all those who play a significant role in that patient's life, including the patient's individual or group therapist, should (with the patient's permission) have explained to them the basis for the medication regimen, the anticipated effects and side effects, and the probable duration of treatment. The role of education is particularly important because psychopharmacology is constantly changing in response to new research, clinical experience, and the introduction of new agents. Information available in the standard textbooks does not reflect the latest state of clinical practice.

Patients' psychological responses. In the treatment of most medical disorders, physicians show minimal concern about the patient's psychological responses to drug treatment. For mental health professionals the situation is reversed. Behavioral and dynamic issues that arise because of drug therapy become of importance in the treatment process. However, the psychodynamic influences of pharmacotherapy in group settings involve not only the patient receiving medication but also the other group members, the group as a whole, and the therapist or therapists (Rodenhauser, 1989). Behavior and attitudes in regard to pharmacotherapy can provide an opportunity to further understand the patient and may serve as a tool in the service of therapeutic change.

The act of prescribing medication is invariably accompanied by complex phenomena that transcend the direct biological actions of the given drug. The *placebo effect*—a phenomenon in which a person exhibits a significant clinical response to a compound that is pharmacologically inert—is the most obvious example of that effect. Other psychological responses to the use of medication may determine the ultimate success of treatment, mainly by affecting patient compliance.

Patients often perceive the need for pharmacotherapy as evidence that they are sicker than if treatment consisted of psychotherapy alone. In some patients, taking medication confirms their worst fears. They already feel different and alienated from normal society; the medication, they

**Table C.6-1
Drugs and Classes of Drugs Used in the Treatment of Major Psychiatric Disorders**

Aggression (see Episodic dyscontrol disorder)	Dopamine receptor antagonists
Akathisia (see Drug-induced extrapyramidal movement disorders)	Lithium
Alcohol-related disorders	Valproic acid
β -Adrenergic receptor antagonists	Generalized anxiety disorder
Benzodiazepines	β -Adrenergic receptor antagonists
Carbamazepine	Barbiturates and other similarly acting drugs
Lithium	Benzodiazepines
Anorexia nervosa (see Eating disorders)	Buspirone
Anxiety (see also specific anxiety disorder)	Serotonin-specific reuptake inhibitors
Antihistamines	Tricyclic and tetracyclic antidepressants
Barbiturates and other similarly acting drugs	Obsessive-compulsive disorder
Benzodiazepines	Serotonin-specific reuptake inhibitors
Bipolar disorder	Tricyclic and tetracyclic antidepressants (especially clomipramine)
Benzodiazepines (especially clonazepam)	Opiate-related disorders
Calcium channel inhibitors	Clonidine
Carbamazepine	Methadone
Dopamine receptor antagonists	Panic disorder (with and without agoraphobia)
Lithium	β -Adrenergic receptor antagonists
L-Tryptophan	Benzodiazepines (especially alprazolam and clonazepam)
Valproic acid	Monoamine oxidase inhibitors
Bulimia nervosa (see Eating disorders)	Serotonin-specific reuptake inhibitors
Cyclothymia (see Bipolar disorder)	Tricyclic and tetracyclic antidepressants
Delusional disorder (see Schizophrenia)	Parkinsonism (see Drug-induced extrapyramidal movement disorders)
Depressive disorder	Phobias (see also Panic disorder)
Benzodiazepines (especially alprazolam)	β -Adrenergic receptor antagonists
Bupropion	Benzodiazepines
Carbamazepine	Posttraumatic stress disorder
Lithium	Monoamine oxidase inhibitors
Monoamine oxidase inhibitors	Serotonin-specific reuptake inhibitors
Serotonin-specific reuptake inhibitors	Tricyclic and tetracyclic antidepressants
Sympathomimetics	Psychosis (see Schizophrenia)
Thyroid hormones	Rabbit syndrome (see Drug-induced extrapyramidal movement disorders)
Trazodone	Schizoaffective disorder (see Bipolar disorder, Depressive disorder, and Schizophrenia)
Tricyclic and tetracyclic antidepressants	Schizophrenia
L-Tryptophan	Benzodiazepines
Drug-induced extrapyramidal movement disorders	Carbamazepine
β -Adrenergic receptor antagonists	Clozapine
Amantadine	Dopamine receptor antagonists
Anticholinergics	Lithium
Antihistamines	Sleep disorders
Benzodiazepines	Antihistamines
Dysthymia (see Depressive disorder)	Barbiturates and other similarly acting drugs
Dystonias (see Drug-induced extrapyramidal movement disorders)	Benzodiazepines
Eating disorders	Chloral hydrate
Lithium	Sympathomimetics
Monoamine oxidase inhibitors	L-Tryptophan
Serotonin-specific reuptake inhibitors	Violence (see Episodic dyscontrol disorder)
Tricyclic and tetracyclic antidepressants	
Episodic dyscontrol disorder	
β -Adrenergic receptor antagonists	
Buspirone	
Carbamazepine	

may assume, would be an additional cause of ostracism, should its use be exposed. Feelings of shame and demoralization are common.

A common obstacle to compliance is ambivalence about medication or outright hostility to it. To the extent that those attitudes result from a lack of information or from misinformation, the educational value of group therapy can prove helpful. Common misconceptions include the views that psychotropic drugs are a crutch, reflect character weakness, are addicting, and are a form of mind control and that some drugs induce suicidal or homicidal behavior. Myron Weiner (1992) reported that the most significant effects of outpatient group psychotherapy on medical care were a "sharp decrease in the number of hospitalizations and in-hospital days" and an increase in compliance with medication. The use of antipsychotics, which are some of the most difficult drugs in terms of compliance, rose significantly among patients in group therapy.

Ross Baldessarini and Jonathan Cole (1988) described several common circumstances that may interfere with drug therapy, including a complicated treatment regimen involving multiple drugs and divided daily doses, the early emergence or persistence of side effects, the slow onset of therapeutic effects, a low apparent relapse risk experienced if treatment was interrupted, psychosis, organicity, low intelligence, impaired hearing or vision, illiteracy, financial hardship, conflicting obligations of time or money, resentment, lack of confidence or trust, specific psychopathology (paranoid delusions, hopelessness, masochism, anxiety), fear, ambivalence, splitting, passive aggression, passive dependence, denial, sociopathy, substance abuse, poor clinician-patient relationship, and inevitable human error.

Therapists' responses. When multiple clinicians are involved, the resistance to medication may originate from the nonprescribing group therapist. A group therapist, as a result of personal or theoretical bias, may object to the conjoint use of medication, just as pharmacologists may question the effectiveness of psychotherapeutic interventions (Salvendy, Joffe, 1991). Whenever two therapies and two therapists are combined, a difference of opinion may appear about which is the primary treatment. Drug treatment may be perceived not as real treatment but merely as a symptomatic remedy. One prevalent view is that pharmacotherapy is a less valid treatment modality than is dynamic therapy. Pharma-

cotherapy is seen as a treatment of last resort or a necessary evil.

Apart from a lack of understanding about the value of pharmacotherapy, the causes of hostility to drug treatment may reflect competitive feelings toward physicians by those in other disciplines, since they cannot prescribe medication. Hostility may also result from fears that medication may threaten therapists' relationships with patients, diminish their control over the management of treatment, and even diminish the importance of psychotherapies in the eyes of patients. When therapists communicate their negative attitudes toward medication, they put patients in a bind, complicate the treatment efforts, and risk treatment discontinuation. Therefore, therapists should avoid making the use of medication a point of contention. Concerns about the medication should be discussed with the prescribing physician. Many problems can be avoided by being open-minded about the use of drugs and by being knowledgeable about their benefits and risks. Prescribing physicians should communicate with group therapists to educate them about how decisions on drug selection and use are made.

The conduct of group therapy and the management of medication both require considerable expertise. Therapists in both cases need to appreciate therapeutic opportunities and to anticipate and recognize adverse reactions. Therapists must respect the potential contribution of each modality toward getting the patient better.

INDICATIONS

The circumstances by which a patient comes to combined therapy vary markedly. In one scenario the patient is initially seen in one form of therapy and then enters the other. The patient may be in group therapy and remain significantly symptomatic. A referral for medication is then made. Conversely, a patient taking medication may need further assistance in dealing with social and other problems. In that case group and drug therapy, although combined, function as parallel modalities that complement each other.

PHARMACOTHERAPY AND GROUP PROCESSES

When pharmacological agents are used in a group setting, several areas need special consid-

eration, including the group processes, the dynamics of the group members (whether they are receiving medication or not), and the maturity of the group. Even when a group is oriented toward medication compliance, rather than insight, therapeutic group processes become involved. As K. Roy MacKenzie (1990) noted, those processes apply just as strongly to pharmacological management as to psychotherapy.

Group mechanisms play a therapeutic role in medication treatment in a number of ways. Some of those factors are universalization, altruism, learning from others, modeling, guidance, education, identification, reinforcement, peer pressure, ventilation, reality testing, interaction, contagion, imitation, inspiration, consensual validation, and transference.

The group's reactions to pharmacotherapy are best conceptualized in such traditional terms as transference, countertransference, resistance, and identification. For example, medication may become the focus of resistance and thus facilitate the analysis of resistance, removing an obstacle to therapy.

Transference

As a rule, more complex transference reactions appear in the course of treatment during group psychotherapy than they do in individual therapy. Medication often augments or precipitates those reactions, allowing the observation of characteristic behaviors. It may be possible to discern in a patient's negotiations about medication certain traits or behavior patterns that are present in other life situations (Beitman, 1981). A negative transference issue should be suspected whenever the patient displays a seemingly irrational refusal to comply with prescribing instructions. Conversely, overly compliant reactions to a medication regimen may reflect a positive transference reaction. Unusual timidity in the face of medication may indicate the patient's needs for acceptance and nurturing.

Personality Traits and Reactions to Medication

Baldessarini (1977) outlined reactions to medication as they may appear in persons with specific personality traits. For example, obsessive patients may ask endless questions and may ruminate about the details of treatment and provoke

antagonism as a result of debates over treatment; histrionic or impulsive patients may overreact to side effects or may impulsively misuse medication; narcissistic or hypomanic patients may rebel at the thought of drugs' reducing their creativity or physical abilities; depressed patients may be reluctant to take medication; schizophrenic patients may refuse to cooperate fully as a result of suspicions or delusions; and patients with antisocial personality disorder may abuse drugs with euphorialike effects and may provoke stormy encounters over the issue of control.

Other Therapeutic Processes

Seeing those who have responded well to drug treatment makes patients feel more positive than in the past about their treatment outcome. The instillation of hope may also reduce anxiety. Acceptance by others counteracts the shame and the reduced self-esteem linked to the use of medication. Universalization, the recognition that their illness or treatment is not unique, diminishes the sense of being different or alienated. Through identification, the sickest members of the group may take on the attitudes and the behavioral patterns of the relatively healthy members.

The group setting tends to provoke manifestations of unresolved sibling rivalry. That dynamic process may be seen as a competition for the affection of the leader. A patient's request for medication may have as its basis the fact that another group member has started taking medication. The involvement of multiple therapists in a general psychotherapy group creates an opportunity, as MacKenzie noted, to play them off against one another. In one possible scenario, he noted, a group may encourage a patient to address important personal issues that are being enacted with other group members, a process that produces an increase in anxiety. The patient then visits the prescribing psychiatrist for the ostensible purpose of having medications reviewed. Group events are misrepresented or not mentioned at all, and the patient comes away with the recommendation to increase medications and to miss a few group sessions until the patient feels better.

The phase of group formation may influence medication patterns. An immature group—one that is in an early stage of development—experiences greater collective and individual

stress and greater symptomatic behavior than does a mature group. Subsequent requests for medication or the recommendation that a patient take medication may be more appropriately managed by interpretation than by pharmacological agents.

Bernard Beitman (1981) summarized some of the benefits of an integrated treatment approach: the involvement of the patient in the therapeutic process, the strengthening of the therapeutic alliance, the reduction of symptom-engendered interference with effective psychotherapeutic communication, the initiation of change, and the acceleration of the working-through process. Paul Rodenhauser (1989) reviewed the possible positive and negative psychodynamic effects of pharmacotherapy on group members for whom medication is prescribed (Table C.6-2 and Table C.6-3).

Being in a psychotherapy group can alter a member's expectation of a drug effect and subsequently predispose the patient toward a specific type of drug response. That phenomenon has been reported in social groups, where many effects of alcohol often depend more on such fac-

tors as the anticipation of the effect than on the pharmacological properties of alcohol. In a therapeutic setting, that manifestation may be related to identification with other members who had taken or are taking medication for a specific disorder.

MEDICATION GROUPS

A specific application of group procedures and psychopharmacology is the medication or drug group (Table C.6-4). Such groups are homogeneous in that all the members are being treated with the same or a similar type of medication. Because of their common diagnosis or treatment, patients in medication groups may engage quickly. In general, the groups are time-limited. In contrast to the generalized therapeutic objective of psychotherapy groups, drug groups aim to maximize the therapeutic response to the medication and to enhance compliance with the drug regimen. Since the rates of noncompliance with psychotropic drugs are reported to be between 30 and 80 percent, depending on the survey, drug

Table C.6-2
Positive Psychodynamic Effects of Pharmacotherapy on Group Therapy Members

Increased Self-Control	Increased Emotional Connectedness	Technical and Strategic Aspects
Sense of responsibility	Validation of self	Content around which to discuss illness and treatment
Confidence	Alliance against illness	Buying time
Reality testing	Instillation of hope and trust	Providing transitional object in the form of medication
Capacity for engagement	Evidence of caring	Improved overall compliance
Energy	Doing something	Shortened treatment
Independent functioning	Providing immediate effect	
Reduction of internal stimuli	Reduction of distortions	
Reduction of stigma from disturbing behaviors	Reduction of anxiety	

Table from P Rodenhauser: Group psychotherapy and pharmacotherapy: Psychodynamic considerations. *Int J Group Psychother* 39: 449, 1989. Used with permission.

Table C.6-3
Negative Psychodynamic Effects of Pharmacotherapy on Group Therapy Members

Decreased Self-Control	Decreased Emotional Connectedness	Technical and Strategic Factors
Disavowal of responsibility	Increased interpersonal distance	Oversedation
Sick role reminder	A sense of despair and impotence	Possibility of dependence
Confusion about possible double messages	Decreased trust	Risk of side effects
Impaired cognition	Decreased motivation	Noncompliance issues
Psychomotor retardation	Negative countertransference	Distraction from other issues
Affect dulling	Inappropriate disclosures	Risk of abuse and overdose
Increased economic burden		
Community stigma		

Table from P Rodenhauser: Group psychotherapy and pharmacotherapy: Psychodynamic considerations. *Int J Group Psychother* 39: 451, 1989. Used with permission.

Table C.6-4
Characteristics of Medication Groups

Homogeneous
Time-limited
Variable size
Primary goal is enhancement of compliance
Active therapist involvement
Encouragement of learning
Little emphasis on psychological-mindedness

groups are a major application of the group process.

The successful use of medication in groups has been reported with antipsychotic agents and lithium (Eskalith). Because of the severe pathology generally present in the disorders that those drugs treat and because of the unpleasant side effects that those drugs cause, obtaining treatment compliance is often difficult. The group approach has been successfully used to improve adherence to drug treatment among chronic schizophrenic patients (Payn, 1965, 1974), with all the prescribing done during group meetings. Improved acceptance of medication and an improved treatment outcome when couples group therapy was used as an adjunct to lithium maintenance in manic patients has been reported (Davenport, Ebert, Adland, Goodwin, 1977).

A medication group can be used as part of the treatment program for patients receiving depot antipsychotic agents, such as fluphenazine decanoate (Prolixin) and haloperidol decanoate. Because those drugs are most commonly used to treat chronic schizophrenia patients and are generally administered every two weeks, it is standard practice to have certain clinic days each week when a nurse, a physician, and other mental health professionals are present. With a therapy group, patients do not merely wait for their injection, get seen and treated, and then leave. Instead, they can meet as a group with a therapist. Patients leave briefly to get their medications and then return to the group. By providing a regular social and therapeutic activity for the patients, the groups also improve patients' reliability in keeping appointments.

In addition to their compliance-enhancing effect, medication groups also effectively treat patients, educate them, and facilitate socialization. By observing individual patients in the group, the therapist can assess the need for possible additional treatment and, if necessary, can schedule

an individual session for intensive evaluation or treatment.

A crucial role of the therapist in medication-oriented groups is to impart information to the group members. Patients are naturally anxious and curious about their treatment regimens and gain an enhanced sense of control over their medication when they understand its effects. Patients also learn about medication from other group members.

Group Processes

The group processes that play an important therapeutic role in medication groups include education, learning from others, the instillation of hope, peer pressure, reinforcement, and identification. By recognizing those processes, the therapist can make appropriate interventions, especially when faced with adverse events or treatment failures. The group provides a supportive setting to deal with issues that, negatively or positively, result from the use of medication or that affect the use of medication.

Variability

Although all drugs used for a particular disorder are equally effective, as measured by response rates in large patient samples, not all patients respond to the same medications. Moreover, sensitivity to drug side effects may vary from patient to patient. The result of those differences in responsiveness to a drug's therapeutic effects and in sensitivity to side effects is that several patients in a group with the same disorder may be receiving different medications. For example, some patients with panic disorder may be taking imipramine (Tofranil), and others may be taking alprazolam or clonazepam. A group leader must anticipate the need to clarify the reason why patients are taking the medication they are taking.

When the group starts, all the group members should include, as part of their histories, their histories of treatment and why they are currently taking a particular drug. Addressing that issue helps the patients deal with feelings of competitiveness, since some patients may wonder why they have not been given the same drug as another patient or may see another patient doing well and want to try the medication the other patient is taking.

Results

Mistrust of medication and, by extension, of the prescribing physician may change as a result of group therapy. That effect may be most pronounced among patients who have problems with authority.

One study (Higgett, Golombok, Fonagy, Malcolm, 1987) reported the successful use of group treatment as a therapeutic technique in benzodiazepine dependence. The focal point of treatment was the graded withdrawal schedule designed individually for the patients in collaboration with them by one of the therapists. Group interventions were aimed at addressing faulty cognitions concerning benzodiazepine dependence. The techniques included cognitive restructuring, problem solving, and relaxation training. The mechanisms of withdrawal symptoms were also clarified.

Patients receiving long-term or maintenance drug therapy can benefit from long-term support or follow-up groups. Those groups meet infrequently, typically once a month. The groups are also called aftercare groups. In some cases, the groups provide the prescribing physician with the opportunity to assess patients, make adjustments in their medication, and write prescriptions. Such groups help prevent relapse and are cost-effective. The groups encourage compliance, share information on the management of side effects, and give patients the opportunity to communicate about their treatment satisfaction (Rodenhauser, 1989).

SUGGESTED CROSS-REFERENCES

Group dynamics is discussed in Section A.3, countertransference and transference in Section A.9, and the qualities of the group psychotherapist in Section F.1.

References

- Arieti S: Psychotherapy of severe depression. *Am J Psychiatry* 134: 864, 1977.
- Baldessarini R J: *Chemotherapy in Psychiatry*. Harvard University Press, Cambridge, 1977.
- Baldessarini R J, Cole J O: Chemotherapy. In *The New Harvard Guide to Psychiatry*, A M Nicholi, editor, p 530. Belknap Press, Cambridge, Mass, 1988.
- Beitman B D: Pharmacotherapy as an intervention during the stages of psychotherapy. *Am J Psychother* 35: 208, 1981.
- Berg G, Laberg V C, Skuttle A, Arne O: Instructed versus pharmacological effects of alcohol in alcoholics and social drinkers. *Behav Res Ther* 19: 55, 1981.
- Berger F: The use of anti-anxiety drugs. *Clin Pharmacol Ther* 29: 291, 1981.
- Blackwell B: Adverse effects of anti-depressant drugs: Part 1. Monoamine oxidase inhibitors and tricyclics. *Drugs* 21: 201, 1981a.
- Blackwell B: Adverse effects of anti-depressant drugs: Part 2. "Second generation" anti-depressants and rational decision making in antidepressant therapy. *Drugs* 21: 273, 1981b.
- Claghorn J, Johnstone E, Cook T, Itschner L: Group therapy and maintenance treatment of schizophrenics. *Arch Gen Psychiatry* 31: 361, 1974.
- Conte H, Plutchik R, Wild K, Karasu A T: Combined psychotherapy and pharmacotherapy for depression: A systematic analysis of the evidence. *Arch Gen Psychiatry* 43: 471, 1986.
- Covi L, Lipman R S: Cognitive behavioral group psychotherapy combined with imipramine in major depression. *Psychopharmacol Bull* 23: 173, 1987.
- Davenport Y B, Ebert M H, Adland M L, Goodwin F K: Couples therapy as an adjunct to lithium maintenance of the manic patient. *Am J Orthopsychiatry* 47: 495, 1977.
- Davis J M: Antipsychotic drugs. Antidepressant drugs. Minor tranquilizers, sedatives, and hypnotics. In *Comprehensive Textbook of Psychiatry*, ed 3, H I Kaplan, A M Freedman, B J Sadock, editors, p 2257. Williams & Wilkins, Baltimore, 1980.
- Desmond P V, Parwardham R V, Schenker S, Speeg K V Jr: Cimetidine impairs elimination of chlordiazepoxide (Librium) in man. *Ann Intern Med* 94: 788, 1981.
- *Elkin I, Shea M T, Watkins J T, Imber S D, Scotsky S M, Collins J F, Glass D R, Pilkonis P A, Leber W R, Docherty J R, Fiester S J, Parloff M B: National Institute of Mental Health treatment of depression collaborative research program: General effectiveness of treatments. *Arch Gen Psychiatry* 46: 971, 1989.
- Higgett A, Golombok S, Fonagy P, Malcolm L: Group treatment of benzodiazepine dependence. *Br J Addict* 82: 517, 1987.
- Hollon S D, Beck A T: Psychotherapy and drug therapy: Comparisons and combinations. In *Handbook of Psychotherapy and Behavior Change: An Empirical Analysis*, ed 2, S L Garfield, A E Bergin, editors, p 437. Wiley, New York, 1978.
- Jankovic J: Drug-induced and other orofacial-cervical dyskinesias. *Ann Intern Med* 94: 788, 1981.
- Johnson D A W: Drug-induced psychiatric disorders. *Drugs* 22: 57, 1981.
- Kaplan H I, Sadock B J: *Synopsis of Psychiatry*, ed 6. Williams & Wilkins, Baltimore, 1991.
- Karasu T B: Psychotherapy and pharmacotherapy: Toward an integrative model. *Am J Psychiatry* 139: 1102, 1982.
- Lesser I M, Friedmann C T H: Beyond medications: Group therapy for the chronic psychiatric patient. *Int J Group Psychother* 30: 187, 1980.
- *MacKenzie K R: *Introduction to Time-Limited Group Therapy*. American Psychiatric Press, Washington, 1990.
- Mitchell J E, Pyle R L, Eckert E D, Hatsukami D, Pomeroy C, Zimmerman R: A comparison study of antidepressants and structured intensive group psychotherapy in the treatment of bulimia nervosa. *Arch Gen Psychiatry* 47: 149, 1990.
- Nagy L, Krystal J H, Woods S W, Charney D S: Clinical and medication outcome after short-term alprazolam and behavioral group treatment in panic disorder: 2.5 year naturalistic follow-up study. *Arch Gen Psychiatry* 46: 993, 1989.
- Onyett S R, Turpin G: Benzodiazepine withdrawal in primary care: A comparison of behavioral group training and individual sessions. *Behav Psychother* 16: 297, 1988.
- *Ostow M: Interactions of psychotherapy and pharmacology. *Am J Psychiatry* 14: 370, 1983.
- Payn S B: Group methods in the pharmacotherapy of chronic psychotic patients. *Psychiatr Q* 39: 258, 1965.

Payn S B: Treating chronic schizophrenic patients. *Int J Group Psychother* 24: 25, 1974.

Pulver S: Survey of psychoanalytic practice, 1976: Some trends and implications. *J Am Psychoanal Assoc* 26: 615, 1978.

*Rodenhauser P: Group psychotherapy and pharmacotherapy: Psychodynamic considerations. *Int J Group Psychother* 39: 445, 1989.

Salvendy J T, Joffe R: Antidepressants in group therapy. *Int J Group Psychother* 41: 465, 1991.

Shakir S A, Volkmar F R, Bacon S, Pfefferbaum A: Group psychotherapy as an adjunct to lithium maintenance. *Am J Psychiatry* 136: 455, 1979.

Simpson G M, Edmond H P, Sramek J J Jr: Adverse effects of anti-psychotic agents. *Drugs* 21: 138, 1981.

*Stone W N, Rodenhauser P, Markert R J: Combining group psychotherapy and pharmacotherapy: A survey. *Int J Group Psychother* 41: 449, 1991.

Weiner M F: Group therapy reduces medical and psychiatric hospitalization. *Int J Group Psychother* 42: 267, 1992.