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Combined Treatment for Depressive and Anxiety Disorders

With the exception of personality disorders (discussed in chapter 5), therapists working with patients in combined treatment will primarily be addressing depressive and anxiety disorders. These diagnoses are common in this population, and many of the examples presented thus far have involved patients with these diagnoses. This chapter is designed to discuss the particular dynamics and special issues that emerge in psychotherapeutic and pharmacological interventions in these cases.

COMBINED TREATMENT OF DEPRESSION

As discussed in chapter 2, patients often have both psychological and chemical vulnerabilities to depressive disorders. One metaphor for understanding these contributions, described earlier, is that of tributaries (chemical, psychological, environmental) to a river, where overflow is equivalent to a depressive disorder. In addition, chemical and psychological vulnerabilities can interact. For example, chemical factors contribute to low self-esteem, which can trigger dynamic factors that intensify depressive symptoms (such as the vicious cycles described later). As noted in chapter 5, medication can help to "clear up the field" by treating chemical factors and assessing what symptoms persist.

Evidence continues to grow that combined treatment can have advantages over psychotherapy or medication alone. For example, a large multicenter study on the combined treatment of chronic major depression

compared a form of cognitive behavioral treatment—cognitive behavioral analysis system of psychotherapy (CBASP)—with the antidepressant nefazodone and a combination of the two treatments (Keller et al., 2000). The treatments lasted for 12 weeks with patients who had been ill for at least 2 years. The study showed a significant advantage of combined treatment over either monotherapy.

Controversy continues in terms of whether depressive symptoms or traits not at the level of a major depressive disorder always represent dysthymic disorder or could also be character elements of a depressive personality disorder. In making a distinction, proponents of depressive personality disorder describe its criteria as primarily psychological, as opposed to the primarily somatic and vegetative symptoms of dysthymia (McDermut, Zimmerman, & Chelminski, 2003; Ryder, Bagby, & Schuller, 2002). In depressive personality disorder, mood disturbance need not be central to the diagnosis, and the diagnosis is conceptualized as persisting traits rather than symptoms, particularly "excessive negative, pessimistic beliefs about oneself and other people" (Hirschfeld & Holzer, 1994).

In a study of adult psychiatric outpatients, McDermut et al. (2003) found that depressive personality disorder was not redundant with other Axis I or II disorders. Depressive personality disorder was associated with greater comorbidity (particularly anxiety disorders), more impaired psychosocial functioning, and higher rates of mood disorders and alcohol abuse in relatives, compared to psychiatric patients without depressive personality disorder. Alternatively, Ryder et al. (2002) argue that "despite persuasive evidence for the existence of depressive personality traits, support is insufficient for the inclusion of depressive personality disorder as currently defined" (p. 337). No medication studies have been done on depressive personality disorder to assess if symptoms respond. Therapists, however, need to be alert to the possibility that persistent depressive symptoms may represent ongoing chemical vulnerabilities that could be further diminished with additional medication intervention.

For instance, Ms. XX had a high chronic expectation of rejection from others. She felt that, unless she was warmly regarded by everyone she knew, that meant she was being rejected. In fact, Ms. XX simply felt as if rejection were taking place and would search out some kind of evidence to confirm that it was occurring. Psychiatric evaluation indicated the presence of a major depressive disorder, with a panoply of cognitive and vegetative symptoms. In addition, Ms. XX's developmental history suggested a variety of psychological vulnerabilities, based on a family background that included an intensely critical mother and a neglectful father focused on his business activities. In essence, Ms. XX felt rejected by her parents, and her subsequent expectations of rejection appeared to mirror this pattern.

After treatment with an antidepressant (she responded well to higher doses of venlafaxine), Ms. XX's depressive and vegetative symptoms eased significantly, but her expectation of rejection continued to be very strong. The psychiatrist/therapist viewed these remaining symptoms as

depressive personality traits and therefore shifted to a predominantly psychotherapeutic approach. He helped Ms. XX to understand her expectation of rejection as related to early traumatic experiences, and he looked at how her angry reactions to these expectations became internalized, leading to intense self-criticism.

Despite an increasingly sophisticated conception of the dynamics by therapist and patient, the intensity of Ms. XX's low self-esteem persisted. The therapist wondered whether anything more might be done to ease these symptoms with additional pharmacological intervention, despite the absence of vegetative symptoms. In terms presented previously, the therapist was assessing whether the patient had an obstruction (an ongoing chemical vulnerability), rather than a resistance, to psychotherapy. He decided to recommend the addition of bupropion, to which the patient agreed. This intervention led to a further reduction in her expectation of rejection and feelings of inadequacy, which aided the therapist and patient in insight-oriented work. The case suggests the need for ongoing attention to both chemical and psychological contributors to symptoms in the treatment of depression.

Dynamics of Depression

Psychoanalysts have been writing about the dynamics of depression since early in the development of psychoanalytic theory and clinical work. Awareness of these dynamic factors can guide therapists in their psychodynamic psychotherapeutic interventions and are also relevant to medication management in a combined treatment. Drawing from the work of several psychoanalytic theorists and research on psychological factors in depression, Busch, Rudden, and Shapiro (2004) delineated five central dynamics in depressive disorders. These include:

- Narcissistic vulnerability: This refers to a sensitivity to perceived or actual losses or rejections. Individuals with narcissistic vulnerability will tend to perceive more events as rejections or losses and react to them with a greater degree of loss of self-esteem, depressive affects, and rage.
- Conflicted anger: Anger at others is experienced as either difficult to tolerate or unacceptable, triggering self-criticism and/or guilt. These reactions can indicate a turning of anger against the self.
- Severe superego: The superego represents the conscience function of the individual; patients who are vulnerable to depression are likely to have a particularly harsh or rigid superego. The severe superego is associated with an intolerance of a variety of feelings, including anger, sexuality, and envy, leading to self-criticisms, an associated lowering of self-esteem, and expectations of punishment.

- Idealized and devalued perceptions of self and others: Patients prone to depression will tend to idealize others with a fantasy that connections with them will compensate for their low self-esteem. However, these idealizations often lead to disappointment and depression. Patients may devalue others to bolster their own self-esteem and to protect against feeling rejected.
- Defense mechanisms: To protect themselves from painful affects, depressed patients tend to employ particular defenses, such as denial, projection, passive aggression, and reaction formation. However, these defenses paradoxically exacerbate depression, as patients are not able to deal directly with the feelings that are being triggered. For instance, anger that is projected leads to experiencing others as more negative or critical, passive aggression tends to arouse ire in others, and reaction formation can lead to individuals being overly nice to those with whom they are angry.

Cognition, affects, and conflicts involved in the dynamics of depression lead to vicious cycles that intensify depressive affects. In one formulation, perceived rejection triggers anger as described previously. This anger, which causes conflict, shifts to guilt and self-criticism. The self-criticism intensifies feelings of low self-esteem, which increases the sense of rejection and level of narcissistic vulnerability.

In a second vicious cycle, low self-esteem leads to a propensity to idealize others to ease low self-esteem. However, this idealization often triggers disappointment and devaluation of self and others, with a further lowering of self-esteem.

Depressive Dynamics and Combined Treatment

The dynamics of depression described earlier affect patients' expectations of and reactions to medication. The experience of shame in response to medication was discussed in chapter 5, in a case that focused on fears of lack of control of feelings, related to identification with the mother (Ms. EE). If patients have a sensitivity to rejection or perceive experiences in the context of their low self-esteem, the recommendation of medication can be viewed as another narcissistic injury.

For example, Busch et al. (2004) described the case of a patient (Ms. AAA) who saw the need for medication as a sign of being defective in some way. Associated with this feeling of being flawed was a sense that others would reject her for taking medication. This reflected her self-view—particularly as an adolescent, when she felt ignored by her father and by her classmates, viewing herself as unappealing and unattractive. These feelings led the patient repeatedly to reduce the dose of her medication, leading to exacerbation of her depression, a furthering decrease in self-esteem, and additional humiliation triggered by evidence of her

need for medication. Exploration of the link of medication to experiences of feeling ignored or rejected in adolescence improved her attitude about medication and increased her compliance.

Difficulties With Anger Management

Patients with depression often struggle with angry reactions toward others, often resulting from feelings of narcissistic injury. This anger is usually experienced as threatening, so it will often emerge indirectly. For instance, anger can be denied and take the form of passive aggression, projection, or reaction formation, defenses found in depression as noted before. The following case describes an instance where passive aggression became involved in the medication treatment, allowing exploration of this issue and a link to other instances where this defense was operative.

Ms. YY, a 45-year-old woman with a long history of recurrent severe depression, had a fear of expressing her anger that stemmed from several sources. She was concerned that others would reject her if she became angry. In addition, she was worried about being hurtful or damaging to others through expression of her anger. Each of these fears mirrored her experience of her mother, who withdrew from the patient in silence for days if one of the children got mad at her, and viciously attacked others in a way that disrupted her close relationships.

Because of her intolerance of anger, Ms. YY would often behave in a highly passive–aggressive manner, resisting the expectations others had of her. For instance, Ms. YY would come late to work, even when she knew that her boss was particularly troubled by this behavior. The therapist would interpret the patient's underlying anger, which she typically denied; she stated that the problem stemmed from difficulties with the snooze button on her alarm. However, over time the therapist was able to point out a pattern in which Ms. YY's passive–aggressive behavior would follow episodes in which the boss behaved in ways she found hurtful.

At one point, Ms. YY became frustrated about a planned reduction in frequency of visits from twice to once a week, even though she had agreed to this plan based on her improvement and wish to save money. In this context, there was a temporary worsening of her depression. As the therapist was exploring the sources of her depression, including feelings of loss of the therapist, Ms. YY revealed that she had been "forgetting" doses of medication. Ms. YY denied being angry at the therapist and did not connect this with her forgetting medication. As this pattern continued, the therapist worked to link this pattern to Ms. YY's anger.

Therapist: What happens when you forget your medication?
Ms. YY: I'm not sure. I mean to take it, but I usually take it at work because I don't have time in the morning, and then work gets too busy.

Therapist: But this did not happen before we planned to reduce the frequency of your sessions.
Ms. YY: No. Only occasionally. I know you see the two events as connected, but I really don't feel that.
Therapist: Well, it seems similar to your behavior with your boss. When he criticizes you, you'll often oversleep and come late to work. We've found that somehow when you're angry you don't realize it and you express it in this indirect way.
Ms. YY: It does seem similar to that pattern.
Therapist: How are you feeling about the reduction in visits?
Ms. YY: Well, it's been difficult. I miss coming here. And sometimes I wish you could reduce your fee to make it easier for me.
Therapist: Well, perhaps you're angry at me about that.
Ms. YY: Yes. I guess that's possible.

Guilt and the Severe Superego

As noted before, patients with depression often struggle with the sense that they have done something wrong and should be punished in some way for this. Often these fantasies relate to conflicts about particular kinds of feelings, including angry, vengeful, dependent, or sexual feelings that are felt to be intolerable or unacceptable. In psychoanalytic terms, this is conceptualized as a severe superego—the conscience function that monitors the individual's thoughts, feelings, and behaviors, rendering some form of judgment as to whether they are acceptable, and determining whether praise or punishment should be meted out. Although not a focus in the case involving a negative reaction to effective medication described in chapter 5, the severe superego can affect the tolerance of positive results from medication. Patients may feel they do not deserve the improvement they are getting, or may be threatened by the potential to experience more actively the intense feelings that trigger guilt.

Ms. ZZ, for example, was a 35-year-old woman with a history of recurrent depression. Contributing to her depression was the tendency toward reaction formation, often doing things for others even if she was angry with them. For instance, Ms. ZZ regularly arranged visits with her father at his request, even though he often canceled them or ridiculed her when they got together. He was critical about a variety of her behaviors: her clothing, work, and friends. If she did not get together with him, she felt guilty, with a sense that she was hurting him and he would feel sad and lonely. In therapy, Ms. ZZ also became aware of a fantasy that if she were nice to her father at some point he would suddenly become nice to her. Therefore, she hesitated to confront him about his attitudes. However, she was recurrently disappointed after these efforts did not lead to positive changes in their relationship.

As she improved with antidepressants, Ms. ZZ began to shift in her attitudes toward her father. At that time her father had setbacks in his work and with a woman to whom he was engaged. Ms. ZZ noticed herself having the thought, "Now he can see what it's like to suffer. I hope he loses his job and his girlfriend." Whereas in the past intense guilt would have precluded any conscious awareness of vengeful fantasies, she was now able to talk to her therapist about these feelings. However, direct expression of the fantasy triggered a wave of guilt.

Ms. ZZ: I don't think it's right to have this kind of thought.
Therapist: What do you feel is the problem with it?
Ms. ZZ: It's mean. I don't really want him to suffer. Do other people have these kinds of thoughts?
Therapist: They're actually quite common. We need to understand what upsets you so much about it. It doesn't seem as if you're actually acting in a vengeful way toward your father.
Ms. ZZ: I felt certain you were going to be critical of my thinking this—that you wouldn't want to be with me.
Therapist: It sounds like the kind of criticism you often expect from your father.
Ms. ZZ: Yes. That's true. And, no, I haven't been mean to him. In fact, I'm still too nice!

The therapist's nonjudgmental stance furthered Ms. ZZ's ability to tolerate and explore fantasies of revenge. Work with both medication and therapy eased the restrictions of her superego, the guilt she experienced, and the punishment she thought she deserved. As she became more comfortable with criticisms of her father, the reaction formation diminished, and she was able to set better limits and become more tolerant of not being able to develop a closer relationship with him.

Idealization and Devaluation

Partly related to current cultural factors in the United States (see chapter 4), patients can develop very high expectations of what medication can accomplish for them. One basis for this expectation is direct-to-consumer advertising, which paints a very positive portrait of medication. It is not unusual for patients presenting with a request for a medication seen on a commercial. In addition, *Listening to Prozac* (Kramer, 1993) was interpreted by many readers as an indicator that problems previously viewed as personality difficulties could respond to medication interventions; patients would allude to examples in the book of people who felt "better than ever" on Prozac.

Per the dynamics discussed previously, medication may be idealized in an attempt to relieve depression and low self-esteem. However, this idealization greatly increases the propensity to disappointment and, subsequently, devaluation, which can worsen depression and further disrupt therapy. The next case describes a patient whose tendency to idealize and devalue affected her experience of medication.

Ms. AAA was a 32-year-old woman with a long history of depression who presented with typical symptoms of a major depressive episode. She reported that she had felt the best she ever had, "better than normal," for a brief period when she first went on fluoxetine 5 years previously. Although it was possible that Ms. AAA had a hypomanic response to medication, she denied other signs and symptoms of hypomania. However, after about a month, her "usual" mood returned. Since then she had undergone numerous medication trials, but the intense positive feeling had never returned. Ms. AAA stated that she had come in specifically to find a medication that made her feel the same way.

Ms. AAA described a series of disrupted relationships with men that were reminiscent psychologically of her experience with medication. She developed intensely positive feelings for them and was subsequently disappointed by their behavior, after which she broke up with them. Although this pattern suggested a co-occurring diagnosis of narcissistic personality disorder, Ms. AAA was not interested in psychotherapy for these problems. She stated that if she found the right medication, she would feel better, and she hoped the doctor would provide that. In a similar fashion to her other patterns, she had heard very positive things about the psychiatrist's psychopharmacological skills and hoped he could find the needed medication.

The therapist responded that he would certainly try to find an effective medication (there were a few medications that had not been tried), but he was concerned that the desired effect would not be achieved and that she would be disappointed in him as well. He also suggested psychotherapy to better understand her pattern of intense excitement about relationships and the first medication, followed by severe disappointment. However, Ms. AAA maintained that she was not interested in psychotherapy. After two medication trials that did not achieve the desired result, she dropped out of treatment.

In addition to the pattern of idealization, Ms. AAA also devalued the therapist, not accepting his suggestions on what might be helpful. Devaluation can reflect a self-critical feeling arising out of guilt and/or a projection onto others of feelings of worthlessness. In addition, a patient can devalue others in order to boost his self-esteem. Unfortunately, this negative view reduces the value of others in the patient's mind, diminishing the potential to feel helped or supported by others. In addition, as noted earlier, devaluation can increase the pressure toward idealization to relieve depression, creating a vicious cycle. This cycle may have been involved in Ms. AAA's patterns with the psychiatrists and medication.

In a related vein, patients may devalue medications before actually receiving them. Patients may state that medication will be ineffective, due to the severity of their depression or by seeing others, including the psychopharmacologist, as unable to help them. Additionally, patients may claim that the medication would be damaging to them because these agents are not "natural."

Countertransference With Depressed Patients

Several countertransference problems can affect the combined treatment of depressed patients. Particularly in more severe cases, therapists can develop countertransference feelings that match the patient's pessimism and experience feelings of hopelessness and inadequacy about their treatment. This negative view can occur in response to patients' efforts, both conscious and unconscious, to convince therapists that their situations are hopeless. The development of this attitude is more likely if patients are dealing with setbacks in their lives, such as loss of a job, financial status, or important relationships. It is important to remember that patients can suffer from a depression no matter what their external circumstances are. Therapists need to be alert to a "giving up" that can cause less aggressive pharmacotherapeutic interventions or a feeling of impotence with psychotherapy.

For example, Mr. BBB suffered an exacerbation of a chronic depression after separation from his wife and loss of his job. He began to experience catastrophic feelings about his situation that were intensified by difficulty finding a new job. Mr. BBB presented an extended series of reasons as to why finding a job would be difficult, including his age and skill level. He was intensely self-critical about having been laid off, even though he had believed it would be good to leave and was finding the job intolerable.

The therapist found himself feeling increasingly concerned about the precariousness of Mr. BBB's situation. At that point, he recalled that Mr. BBB was similarly depressed when he was working and married. The patient had felt that he was consumed by the needs of others and could not follow his own interests. Leaving these situations had initially triggered a feeling of freedom that he had not experienced in many years.

Therapist: In our prior discussions you felt very upset by your marriage and your job.

Mr. BBB: Yes. That's true. But I hadn't anticipated the loneliness I would feel. And it's very strange not working. I had looked forward to going to museums, but there are only so many museums you can go to.

Therapist: I also think it's hard for you to adapt to the feeling of not having so many responsibilities. You've always felt under so much pressure to take care of others.

Mr. BBB: Yes. I felt very burdened by that. But I think it also helped me to feel important.

As the therapist recognized Mr. BBB's pessimism and self-criticism, he realized that the patient might be having a recurrence of depression. The therapist had been affected by Mr. BBB's presentation of negatives in his life, and this initially prevented his considering the possibility that the depression had returned. An evaluation revealed the presence of typical symptoms of a major depression. Therapist and patient then shifted to a discussion of an adjustment of Mr. BBB's medication, and it was determined that lamotrigine should be added to his current regimen. This intervention significantly relieved Mr. BBB's depression and helped him to pursue new job options and relationships. An exploration of his overresponsibility and caretaking of others was an important issue in the psychotherapy at this time.

Another countertransference response to depression occurs when patients present themselves as worthless and describe accepting mistreatment by others in their lives. Therapists may be affected by the sense that these patients do not deserve the usual care. In these instances, therapists should be alert to a propensity to reschedule patients frequently, not call in prescriptions quickly, or minimize side effects. An instance where this occurred is the case of Ms. Y, described in chapter 5, who accepted mistreatment by others in her life. After several instances in which the therapist requested a time change, she revealed that she felt as if the therapist viewed her as a second-class citizen. The therapist admitted his error in the frequent rescheduling, and they were able to explore this productively in psychotherapy.

Therapists also should be alert to anger in response to patients' resistance to medication, whether expressed indirectly through passive aggression, as in the earlier case of Ms. YY, or directly in rebellion, as noted in the case of Mr. DD in chapter 5. Additionally, therapists can get angry when patients do not improve, experiencing the stasis as a narcissistic injury to their therapeutic skills. Finally, in instances involving projection, therapists can be frustrated by patients' views of them as hurtful and rejecting.

Psychopharmacologists who are not as familiar with monitoring countertransference may be provoked by these various attitudes and behaviors into acting in rejecting ways, such as firing the patient. Nevertheless, even experienced therapists can be negatively affected by more complex depressed patients and need to be alert to more subtle manifestations of rejection. Thus, acknowledgment of countertransference is important to avert disruptions in psychotherapeutic and psychopharmacological care.

COMBINED TREATMENT OF ANXIETY DISORDERS

The focus of this section will be on panic disorder and generalized anxiety disorder (GAD), but aspects of the psychopharmacological and psychological theory and treatment of panic and GAD overlap with other anxiety disorders. In addition, we will briefly address issues in combined treatment of obsessive–compulsive disorder.

As with depressive disorders, anxiety disorders also likely derive from both chemical and psychological sources. Gorman, Kent, Sullivan, and Coplan (2000), for example, suggested that panic disorder involves an oversensitive fear network, comprising the prefrontal cortex, thalamus, amygdala, brainstem, hypothalamus, and other brain structures. The central component of this fear system is the amygdala, which coordinates physiological and behavioral reactions to danger. Both brainstem structures and cortical areas have input to the amygdala, allowing, respectively, an immediate and more processed response to danger. Relief of anxiety disorders from an oversensitive system can occur "top down," from psychotherapy increasing the ability of the cortical system to override automatic responses from the amygdala (Gorman et al., 2000; LeDoux, 1996), or "bottom up" through effecting an impact on brainstem and amygdala systems with medication.

Thus, the use of combined psychotherapy and medication is frequent in the treatment of these problems. Pharmacological treatment of anxiety disorders typically involves rapidly acting, as needed, use of benzodiazepine agents and/or longer term interventions with antidepressants with antianxiety functions that take effect gradually. The use of benzodiazepines can often allow patients to achieve a level of comfort while the therapist initiates psychotherapeutic management of the anxiety disorder, sometimes avoiding the need for an antidepressant. However, in instances of a more severe or persistent disorder, therapists often start antidepressants, but continue to work with a simultaneous psychotherapeutic intervention. Because medication efficacy has been demonstrated and some doctors and patients prefer it, many anxiety disorder patients are treated with medication alone.

As discussed later, anxiety disorders can relate psychologically to conflicts over angry and dependent feelings. Medication intervention may work to ease these conflicts by diminishing the vulnerability to irritability as well as anxiety, reducing the threat from angry and dependent wishes and impulses. In working with patients, a helpful metaphor describes anxiety as an overactivated alarm system that is triggered too easily or sounds a much louder alarm than is necessary. Medication and psychotherapy can each help to ease the catastrophic danger associated with anxiety disorders, calibrating the alarm system.

Notably, medication treatment of anxiety has been seen and is still viewed by some psychotherapists as disruptive of an exploratory psychodynamic process. In this conception, anxiety is of value as a motivator

of treatment and as a signal of unconscious conflicts (see chapter 1); the signal suggests a pathway for the therapist and patient to explore to gain information about the patient's intrapsychic conflicts (Roose, 1995). One way to conceptualize this issue is that a certain level of anxiety is of value in this regard, but catastrophic levels of anxiety are disruptive rather than helpful. It is the catastrophic levels that are the intended target of medication. In some instances, patients will lose motivation for psychotherapy when their anxiety is relieved with medication. Depending on the particular circumstances, this may or may not be a problem with regard to therapeutic outcome.

Dynamics of Anxiety Disorders

From the psychodynamic perspective, anxiety disorders are typically viewed as related to unconscious or preconscious affects and wishes that are felt to be unsafe in some way or that trigger conflict. Prominent among these are angry feelings and fantasies, alongside dependency longings and wishes. Patients with anxiety disorders often experience insecure attachments and see their dependency wishes as dangerous because they feel they cannot safely count on others to respond to their needs and fears. In this context, vengeful feelings and fantasies can become particularly frightening as concerns emerge that the enactment of these wishes will cause a further disruption of the relationship with needed others.

These dynamics combine with different defense mechanisms and chemical vulnerabilities to produce the various anxiety disorders. In specific phobias, for example, anger is projected and displaced to objects in the environment, which are then avoided to ease the fear. In Freud's case of the child Little Hans (Freud, 1909a), the child's unconscious angry and competitive wishes toward his father were experienced as threatening. These wishes were then projected, seen as coming from the environment, and displaced onto horses, which symbolized the father. Thus, the patient feared that the horse (father) would damage him rather than that he would hurt his father.

In a psychodynamic investigation of panic disorder, Busch et al. (1991) and Shear et al. (1993) presented a model in which individuals prone to panic disorder develop a fearful dependency on others based on a neurophysiological vulnerability or traumatic developmental experiences. This fearful dependency, the sense that they are not safe without the presence of others, becomes a source of narcissistic humiliation as the individual feels incapable of managing independently. The humiliation leads to anger, but this anger creates anxiety because the individual fears damaging the relationship with the needed other.

Ultimately, a vicious cycle of fearful dependency, narcissistic humiliation, anger, increased anxiety, and fearful dependency occurs. Defenses are triggered, including reaction formation, undoing, and denial, that

attempt to minimize anger and intensify affiliative efforts. However, these defenses prove unsuccessful, and the failure of the signal anxiety function of the ego leads to panic. Panic symptoms minimize access to anger and maintain attachment through a desperate plea for help.

Milrod, Busch, Cooper, and Shapiro (1997) identified four dynamic factors they found to be relevant to the psychopharmacological treatment of panic disorder; these overlap with issues found in anxiety disorders in general:

- Intense anxiety can be experienced as a sign of weakness, and patients often feel humiliated about the presence of severe anxiety. They may react by developing a counterphobic view of themselves as "strong." Thus, patients may view medication as a symbol of their weakness or struggle against medication because of the need to avoid feelings of humiliation.
- Recommendations for medication can arouse dependency wishes and conflicts in patients. They struggle between wishes to be cared for and fears they will be abandoned or intruded upon in response to dependency longings.
- Patients with anxiety disorders often have fears of losing control. These fears can be greatly intensified by medication and exacerbated by side effects. Fears of loss of control over their bodies can relate to frightening angry fantasies. These patients often need significant reassurance about the safety and value of medication.
- Fears and wishes regarding pregnancy as well as pregnancy itself constitute a special category of medication issues. Fears about pregnancy include fantasies of bodily damage and losing control, including concerns about harming the child. Additionally, becoming a mother often disrupts dependency wishes because of having to take care of others rather than be taken care of. Patients may avoid stopping medication as a rationalization to avoid pregnancy or have exacerbated concerns about bodily damage to themselves or the fetus from medication.

In addition to the dynamics described previously, anxiety symptoms both symbolize and avert frightening unconscious feelings and fantasies. Diminished anxiety symptoms with medication can bring these feelings more directly into consciousness. Improvement can also threaten dependency because the patient's symptomatic preoccupation may have been employed unconsciously to engender caretaking behavior from others. For these reasons, medication intervention can be experienced as threatening or destabilizing.

Feelings of Weakness and Needing Medication. As noted earlier, patients with anxiety disorders struggle with feelings of narcissistic injury about anxiety symptoms. Therefore they will sometimes find the need for

medication to be humiliating. In addition, due to their internal representations of others as being rejecting or abandoning, anxious patients may anticipate the therapist behaving toward them in critical or humiliating ways. Anger that is denied can be projected onto others, exacerbating patients' experience that the therapist will be undermining or attacking. Thus, the introduction of medication could be interpreted in a similar way (e.g., the therapist pointing out that they are unable to function). Medication may also be viewed as suggesting that patients' fears are even less manageable than they have felt. Counterphobic efforts to be "strong," as a means of avoiding or denying anxiety and humiliation, can lead to struggles about the need for medication..

Ms. CCC, a 70-year-old woman, developed the onset of panic attacks associated with fears of being alone. She attributed her panic to breathing difficulties she associated with mild chronic obstructive pulmonary disease. However, her internist and pulmonologist felt that her medical condition could not account for the degree of difficulty that she experienced with her breathing. She presented on alprazolam 0.25 mg once a day, which she had been given by a psychiatrist in an emergency room, who had explained to her that she was having panic attacks. She also had developed depressed mood and mild vegetative symptoms, which she felt were secondary to her frustration with her anxiety. During the evaluation, Ms. CCC initially denied any preexisting anxiety or significant stressors.

The therapist suggested psychotherapy plus an increase in alprazolam to 0.25 to 0.5 mg every 4 to 6 hours as needed. Because of the severity of the panic and increasing depression, the therapist also suggested a trial of sertraline. Ms. CCC, however, was resistant to these suggestions, stating that she did not like taking medications. Over the next few days, Ms. CCC's panic persisted. In phone contacts, it emerged that Ms. CCC had not increased her alprazolam dose beyond the 0.25 mg daily dose she had started with, despite ongoing therapist suggestions. In addition, Ms. CCC was resistant to come in for additional sessions, stating she wished to go back to her country home.

In the next session, Ms. CCC discussed more about the history of her anxiety. She revealed that a milder form of anxiety had begun the previous summer. This was just after she was laid off her job as an editor, which she had had for over 40 years. She was both humiliated and angry that this had occurred, especially after her many years of service. She began to face the prospect of what she would do with more time and less structure in her life. Fortunately, work on her house commanded her attention, although she was more concerned about being able to pay for the work without her job.

Although in the city she had regular activities, when she had returned to her country home 2 months previously, she had felt there was too much time on her hands. While she had previously prided herself on her independence, she began to greatly miss her husband, who would come out only on weekends. At this point, she had the onset of panic and terror of

being alone. Ms. CCC was humiliated by these symptoms, thus adding to her resistance to treatment, but felt desperate for help. The therapist explored these feelings in the context of medication treatment.

Therapist: You seem to be in a lot of conflict about getting help for this problem.
Ms. CCC: I hadn't really thought of it that way.
Therapist: Well, you want to come to sessions but then talk about leaving for the country as soon as possible, and you are reluctant to increase the medication to a higher dose.
Ms. CCC: I really don't like medication.
Therapist: What is it that you don't like about it?
Ms. CCC: I'm not really sure.
Therapist: From what you told me I wonder if you feel embarrassed about needing it—that it's a sign of how much help you need when you're used to being so independent.
Ms. CCC: Well, that could be true. I certainly don't like being in this position.

Conflicts About Dependency and Taking Medication As described earlier, patients with anxiety often suffer from dependency conflicts that stem from and exacerbate their anxiety. Patients long for caring from others, but also struggle with these wishes. Sources of these conflicts include humiliation about needing help and fears that others will respond to their needs with abandonment or intrusion. However, the effort to deny dependency wishes often only exacerbates them because patients become unable to communicate directly about the response they desire from others. As noted previously, these conflicts can involve medication: Patients long for the relief it may provide, but fear the dependency that the medication signifies.

For example, dependency conflicts played a role in Ms. CCC's struggle with medication. Curiously, fears of becoming dependent were focused on antidepressants rather than benzodiazepines, which do contain some risks of physiological dependency. These concerns in part related to her feelings of humiliation in needing medication as described before. There was a long-standing focus on viewing herself as independent, capable of handling things on her own emotionally. This appeared to derive in part from problems in her early life resulting from a mostly absent alcoholic father, and a frequently absent mother who had to work two jobs in order to support the family. The need to manage on her own was linked to an identification with her mother and a counterphobic need to deny her intense longing for care, which had been met in very limited ways. Thus, Ms. CCC found benzodiazepines, where she made the decision to take them, less threatening than antidepressants, which she perceived as being imposed on her.

Ms. CCC: I don't want to be dependent on the medication.
Therapist: What do you mean by that?
Ms. CCC: You know. End up having to take it for the rest of your life.
Therapist: Actually, antidepressants really don't have a risk of dependency in the way that people usually think of it. It's not that if you stop you would feel a pressure or urge to take the medication.
Ms. CCC: Well, that may be, but I still don't like it.
Therapist: I wonder if part of the issue is that for so long you've been doing things independently. From what you told me you've felt on your own much of the time since you were a child. It's important for you, but it's been much harder since you've lost your job, since you have to lean on others.
Ms. CCC: My mother didn't like us to bother her much. She was very busy just trying to keep the household going. And I don't think my husband likes it either. He's not used to my being like this. He gets really annoyed.
Therapist: Well, I think these are important issues to work out, but I think that the medication has become caught up in your conflicts and fears about being taken care of. You feel that, if you are not deciding when to take the medication or feel dependent on it, you may end up feeling rejected.
Ms. CCC: Well, I'm certainly not used to being in this position, and I guess the medication reminds me of needing help.

Ongoing explorations of Ms. CCC's feelings of humiliation and fears of dependency were of value both in her increasing acceptance of medication and in understanding how these conflicts affected her anxiety more generally.

Fears of Loss of Control Fear of losing control is a central feature of the dynamics of anxiety disorders. Patients typically fear, usually unconsciously, the emergence of forbidden feelings and fantasies. They are concerned these dependent and angry wishes will be expressed in ways that are damaging to themselves and others. Medication will often become caught in these conflicts because patients' fears can be projected onto the medication, which then becomes a source or expression of fantasies of damaging loss of control.

Ms. DDD was a 43-year-old mother of two whose panic attacks emerged in the context of fights with her older child, a daughter who was 15 years old. Ms. DDD was aware of being "too nice" with her daughter and had trouble setting limits. She quickly grasped that this was part of a more general pattern of unassertiveness. This included fears of confronting a temperamental and alcoholic father, a frequently absent mother, and a controlling, domineering older sister. Unconsciously utilizing reaction formation, Ms. DDD became "too nice" to others with the hope that her attachments would be less disrupted and she would not drive others away.

Because of the severity of her panic attacks and some mild depressive symptoms, the therapist/psychiatrist decided to begin a sertraline trial. Recognizing the importance of beginning medication at low doses in patients with anxiety, Ms. DDD started on 25 mg/day. However, on this dose, her reaction was quite severe: She experienced palpitations, intense anxiety, and feelings of being out of control shortly after taking her first pill. It was difficult to differentiate her usual panic from the reaction to medication that she described; however, Ms. DDD was convinced medication was the culprit. She agreed to take 12.5 mg/day, but had a similar reaction. The therapist addressed Ms. DDD's reaction with her.

Ms. DDD: I don't want to try it again. I'm afraid of losing control.
Therapist: This is a very strong reaction to this low dose of medication. I'm not sure what you mean when you say you're afraid of losing control.
Ms. DDD: I'm not sure either. But I was thinking about it and I do know that my father and sister have terrible tempers. I know that my father was out of control when he was angry.
Therapist: So you feel you might be worried about losing control of your anger?
Ms. DDD: I guess so.
Therapist: Are you angry about taking the medication?
Ms. DDD: I'm not sure. I know you want me to take it, but I'm not sure if I want to.
Therapist: Well, I guess we need to discuss this further, as these feelings seem to be increasing your anxiety right now. It seems like you are being "nice" with me like you often are with others.
Ms. DDD: Possibly.

Further psychotherapeutic work in Ms. DDD's case confirmed that her panic attacks and fears of loss of control were triggered when she felt she had to yield to others and was angry about this submission. Although Ms. DDD remained off antidepressant medication, her intense reaction and its transference manifestations provided valuable information in understanding her panic symptoms. Her symptoms responded to psychotherapy and a minimal dose of as-needed benzodiazepines.

The Transitional Object Function of Medication in Anxious Patients

Medication functioning as a transitional object was discussed in some detail in chapter 4. In this view (Hausner, 1985), the medication can take on the meaning of a safety object, symbolically averting a separation. Fearful dependency and associated separation fears are common in panic and other anxiety patients, who are particularly susceptible to experiencing

the medication in this way. This can be an aspect of the placebo function in medication, perhaps contributing to the high rate of placebo response found for panic patients. Panic patients will often carry medication with them "just in case," thus providing a feeling of safety beyond that from taking the medication. This safety aspect can disrupt patients' ability to taper off medication even when appropriate. In chapter 4, the case of Ms. T described how medication, like other objects of the patient's parents and therapist, provided protection from separation fears. Ultimately, exploration of these objects is important because attachment to them can be a means of avoiding addressing intrapsychic threats.

For example, Ms. EEE, a 35-year-old woman who suffered from panic disorder and occasional depressive symptoms, expressed unwillingness to attempt to taper her 2-mg daily dose of lorazepam, despite a good response to venlafaxine. Ms. EEE described a series of traumatic disruptions early in life when her wealthy parents would leave for extended periods on vacation. In addition, when her parents were at home, she felt that they were not responsive when she needed help. For instance, she described a sleepover in which she was injured, ultimately requiring stitches, but her parents left it to the other family to manage the situation, despite the patient's pleas. Anger at her parents intermixed in this patient with fearful dependency in the cycle described earlier. In exploration of the attachment to her medication other transitional objects emerged.

Ms. EEE: It's not just medication I'm attached to. I have two teddy bears in my bed I've had since childhood. I take them everywhere I go. In fact, my last boyfriend was very upset by them. I don't like to think about being without them.
Therapist: What happens when you do?
Ms. EEE: I feel terrified. Even talking about it now feels very scary. They've always been important to me.
Therapist: I wonder if they were important in protecting you from separation fears when your parents were away.
Ms. EEE: And even when they were there. Because even then I felt like they sometimes weren't emotionally present.
Therapist: Well, I think we should explore these fears further.
Ms. EEE: As long as I don't have to give them up.

The degree of anxiety Ms. EEE experienced in discussing this topic was striking. Exploring associated fears of loss and emptiness, as well as her frightening anger at her parents, helped to better approach the patient's attachment to medication.

Anxiety Disorders and Pregnancy

As noted earlier, pregnancy involves multiple issues for patients with anxiety disorders. Pregnancy can trigger fears of loss of control, damage to the body, aggression toward the child, and loss of the child role. Psychopharmacological treatment during pregnancy is a complex issue, with recommendations against the use of benzodiazepines, particularly in the first trimester, and guarded use of certain antidepressants. Due to underlying fantasies, patients with anxiety may be particularly frightened of potential harm to the fetus from medication.

Ms. FFF was a 30-year-old woman who presented with severe panic symptoms and generalized anxiety disorder, with particular worries about her health. Despite being married and planning to have a child, she was in close contact with her parents regarding her health concerns. She would regularly inform them about her symptoms, review the comments of her doctors, and discuss how to proceed with her care. This advice seeking was part of a more general tendency to get help from her parents about many matters in her life, including clothing, decorating tips, and relationship conflicts.

This relationship appeared to have a long history, with her mother focused on her doing things "the right way" socially from early in her life, although she felt her mother was unable to help her with bullying in her seventh grade class. Health concerns were exacerbated in eighth grade, when her mother developed colon cancer requiring surgery and chemotherapy. Ms. FFF and her parents were also traumatized by a near fatal bout of appendicitis when she went to college. Currently, Ms. FFF felt pressured to submit to her mother's views and to bring her worries to her and greatly feared the loss of this caretaking relationship.

In the setting of plans for having her first child, Ms. FFF developed an exacerbation of her severe panic and comorbid depression. She was started on sertraline with resolution of symptoms, but subsequently was frightened by the idea of getting pregnant on the medication. Exploration revealed a series of concerns about having a baby. Ms. FFF feared losing her dependency on her parents and was frightened about being the mother rather than the child. In addition, it emerged that behind her submission to her parents was an intense anger at her mother's intrusiveness that she found threatening, and she feared this anger would also develop toward her child.

Ms. FFF's conflict became focused on the medication. In accord with a view of the medication as an object (discussed in chapter 4), the medication became the maternal object, which she needed and feared giving up and yet resented because of her feelings of dependency and experience of intrusion. In addition, she feared feeling guilty should anything happen to her child from medication, which was linked to her anger at her future child for forcing her to give up her own childlike position.

Ms. FFF's pregnancy efforts were delayed several months as she struggled with her fantasies about the medication and pregnancy and after a failed effort to discontinue the medication. Ultimately, as these various fears were explored, Ms. FFF understood that her conflicts about pregnancy were being displaced onto the medication. She recognized the exaggerated and conflicted fear she felt about "losing" her parents, as well as the threat of her anger at parent and future child alike. These realizations helped her to understand her anxiety and also to make a decision to proceed with the pregnancy on medication. No problems were evident at the birth of her child.

Combined Treatment of Obsessive–Compulsive Disorder

Obsessive–compulsive disorder (OCD) was an important area of clinical observation and theorizing for early psychoanalysts. In a psychodynamic formulation of OCD, patients are viewed as struggling with aggressive or sexual fantasies and feelings that are considered unacceptable to a severe superego, and they fear loss of control of these feelings. The danger the patient feels is intensified by a regression or persistence of an early stage of ego development, in which thoughts were felt to be equivalent to an action. Defenses are triggered in an attempt to cope with these wishes, such as undoing via compulsive behaviors designed to make restitution for the aggressive and sexual wishes, and intellectualization to minimize frightening feelings.

OCD symptoms can be understood as a compromise formation between aggressive and sexual wishes and the attempt to undo them with penitential acts to ward off guilt and anxiety. Freud (1909b), for example, described the case of a patient who developed a compulsive symptom of moving a stone back and forth into the road to cope with aggressive wishes and ambivalence toward a woman (thinking her carriage would hit the stone) and the need to undo the fantasy of damage. More recent psychoanalytic thinkers view the aggression and guilt as resulting from the experience of critical or neglectful parents (Brandchaft, 2001; Meares, 2001). In this formulation, obsessional symptoms represent efforts to control the threat of disrupted attachments to significant others.

Psychoanalysts have been less focused on OCD in recent years, in part due to the demonstrated efficacy of other approaches (cognitive behavioral therapy and some antidepressants) in treating OCD and evidence of a biological origin in many cases (Esman, 1989, 2001). A combined treatment of OCD is common, and psychodynamic approaches, though not systematically studied, can aid patients through a focus on the meaning of symptoms (Gabbard, 2000, 2001). Fears of loss of control and feelings of shame can arise in the context of exploring symptoms and prescribing medication. The psychoanalytic therapist's nonjudgmental stance can help patients to feel safer about revealing obsessions and compulsions

and taking medication. Transference and countertransference fantasies can be identified to aid patients with problems in interpersonal relationships secondary to OCD.

Leahy, McGinn, Busch, and Milrod (2005) describe the case of a patient, Linda, a 40-year-old single woman whose long-standing rituals of checking the locks and gas and repeated hand-washing had increasingly interfered with her life in recent months. She would also read her horoscope repeatedly, looking for clues about future dangers. These symptoms had worsened in the context of deepening intimacy with her boyfriend, with whom she was considering marriage. Alongside her rituals, she developed obsessional preoccupations that her boyfriend was interested in another woman, with whom he would become involved and then leave her.

Efforts to explore the functions of her symptoms were initially stymied by the degree of her anxious preoccupation. She expressed fear about taking medication, with a worry that others would see her as "crazy," but exploration of feelings of shame relieved her concern. A trial of sertraline significantly reduced her symptoms, allowing further psychodynamic exploration.

Linda described problems growing up with a father who demanded a high level of academic and professional achievement, although she felt ultimately unable to gain his love. Her father was often distant, and there were suggestions that he was involved in affairs with other women. She saw her mother, an anxious and intrusive woman, as incompetent, and she viewed herself as her mother's caretaker. Many of her rituals and obsessions were understood to be efforts to control her fears of rejection, intrusiveness, and anger in the context of her increasing involvement with her boyfriend. Study of her horoscope focused on fantasies that she would be able to determine whether he would reject her. The identification of the meaning of her symptoms combined with medication to further diminish her obsessions and compulsions.

Countertransference Issues With Anxious Patients

Patients with anxiety disorders can induce several countertransference reactions that may affect the use of medication by psychiatrists. Anxious patients can create anxious feelings in the therapist, which could lead to overuse of medication. In these instances, the therapist may be inadvertently, perhaps unconsciously, blocking the emergence of feelings and fantasies that the patient (and perhaps the therapist) find to be frightening. In addition to reacting to the anxiety, therapists should be alert to frustration with patients stemming from their dependency and difficulty taking autonomous steps. Therapists may respond to this frustration by overmedicating in an attempt to eliminate these conflicts or undermedicating as an unconscious expression of their irritation. Subtle or direct criticism or angry expressions will confirm patients' expectations of attack and disrupt the therapeutic alliance.

When prescribing medication, therapists can become frustrated by patients' anxious preoccupations about medications, which sometimes require very slow increases in dosage to aid patients in tolerance. Patients may see medication as representing the damaging hurtful other that needs to be warded off; therapists will sometimes become frustrated with patients' views of the medication, and thereby the therapist, as hurtful or damaging. Therapists should be alert to these reactions because they can provide clues to communicate to patients in a helpful way about factors that lead them to fear or struggle with the prescription of medication.

In the case of Ms. FFF, the patient appeared to be ready to proceed with her pregnancy efforts after addressing a series of fears about continuing the medication. However, Ms. FFF stated that her mother had raised new objections, after speaking with a doctor friend of hers who viewed the medication as unsafe. Ms. FFF felt more time would be needed to get a handle on this doctor's concerns, and her mother felt it was important for the therapist to respond to these issues.

At this point, the therapist became aware of frustration at the patient for this new anxiety about medication and pregnancy. On looking at this reaction, he noted that one component was the narcissistic injury of feeling that his view was not good enough and that another doctor's opinion would trump his. More strongly, however, he felt the urge to tell Ms. FFF, "Look. Just get on with it. That's enough objections already."

This thought helped the therapist to understand more about how the patient induced controlling behavior from others. Her anxious preoccupations and indecisiveness led her mother to intervene more authoritatively with her. This helped to maintain the dependent relationship: Despite Ms. FFF's frustration with her mother's intervention, she often provoked it by presenting herself as incompetent. Communicating this concept to her not only helped her to proceed with pregnancy, but also aided her in examining the ways her behavior exacerbated problems with her mother.