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## *Theoretical Bases of Combined Treatment*

As outlined in chapter 1, psychodynamic therapists and psychoanalysts have increasingly turned to pharmacotherapy as a valuable tool in their clinical armamentarium. It is important to therapist and patient alike to have an understanding of the rationale for combined treatment. The theoretical stance of the therapist will significantly affect his way of speaking to his patient and giving care; that is, his orientation vis-à-vis combined treatment will have an impact on *how* treatment is combined, not only *if* it is combined. Inherent in the notion of combined treatment is a view of the human mind as complex and of the therapeutic endeavor as similarly complex. The clinician's capacity to consider combined treatment is itself a powerful antidote to the dangers of reductionism. Also, combined treatment, by its very nature, invites numerous questions about the nature of suffering that can be complicated by falsely dichotomous thinking. Among the common if not universal questions raised are: Is the illness biological or psychological? Is the problem in the genes or was it caused by stress? Is it the person or his brain? Unless the clinician has considered these questions, he will not be able to explore them constructively with his patient.

In this chapter, we will first examine the theoretical basis within psychoanalysis and dynamic psychotherapy for combined treatment by turning to Freud and to other analysts who have contributed on the topic. We will discuss early attempts within psychoanalysis to understand combined treatment based on a two-illness model, assessing its advantages and disadvantages. The recent integrative efforts of Kendler (2005) will be elucidated as a way of providing the clinician with a comprehensive theoretical and philosophical framework for combined treatment that moves

beyond the more rudimentary two-illness model. Such a framework is necessary to accommodate interactional models that capture the complex dialectic that takes place in trying to combine treatment empathically and competently. The application of more complex models to the clinical situation will be shown to require an inevitable oscillation between different ways of relating (Cabaniss, 1998; Sandberg, 1998).

#### PERSPECTIVES FROM WITHIN PSYCHOANALYSIS

In chapter 1, the basis for the antagonism of dynamic therapists and analysts toward the use of medication was elaborated. There was a rigid adherence to rules of technique that made the use of medication relatively or absolutely contraindicated. Psychic determinism was embraced reductionistically. In the context of these tendencies to exclude the relevance of biological factors, it is important to be reminded that Freudian theory has always accommodated the role of the body as an essential consideration of mental life. Freud's core concept of instinct as existing on the frontier between the mental and the somatic illustrates this. Furthermore, his view of the ego as first and foremost a body ego and his conceptualization of a complementary series reflected an awareness that development always included an interplay between constitutional and environmental factors. Freud's acceptance of the limitations of psychoanalysis and his anticipation of other therapeutics are well known (Freud, 1938):

But here we are concerned with therapy only insofar as it works by psychological means; and for the time being we have no other. The future may teach us to exercise a direct influence, by means of particular substances, on the amounts of energy and their distribution in the mental apparatus. It may be that there are still undreamt-of possibilities of therapy. (p. 182)

While this quote is often seen in papers on pharmacotherapy and psychoanalysis to remind analysts that Freud anticipated advances in drug treatment, it is important to highlight the explicit biological/somatic point of view as essential and irreducible.

Although Heinz Hartmann's ego psychology is now considered part of a bygone era (Bergman, 2000), his writings also provide an explicit and heuristically useful conceptual basis for combined treatment from within psychoanalysis. Hartmann (1939) believed that the mind has areas of functioning that are autonomous and not primarily derived from conflict (affect regulation, impulse control, and attention, for example), yet could become secondarily entangled in conflict. For many psychoanalysts the concept of ego functions operating independently of conflict was the antithesis of a truly psychoanalytic view that emphasized the inevitably conflicted state of the mind. Yet, an important implication of the notion of autonomous ego functions is that they permit a way of thinking about the

role of pharmacotherapy in psychoanalysis: Some patients may be viewed as having impairments in autonomous ego function that could be ameliorated through the use of medication.

Besides Freud and Hartmann, other analysts have looked at how biological factors interact with psychoanalytic models of the mind, but this approach has not been emphasized in the psychoanalytic literature (Cornell, 1985). Kandel (1999) laments the decline of psychoanalysis as not having evolved scientifically in recent decades, in part because it has failed to recognize itself as a branch of biology. While offering the opinion that psychoanalysis embodies the most coherent view of mind, he opined that a dialogue was essential between psychoanalysis and biology in order to achieve a coherent understanding of mind. Combined treatment necessitates and facilitates such a dialogue.

### *The Two-Illness Model*

Whereas the earliest efforts to combine treatment relied heavily on translating drug action into metapsychological terms (Ostow, 1962), subsequent efforts shifted away from this approach and attempted to find the points of intersection that Kandel has encouraged. Psychoanalysts began entertaining multiple models of the mind (Kantor, 1990) or suggesting more pragmatic treatment approaches based on evidence (Roose, 1990), thereby attempting to create a theoretical space in which to consider the usefulness of pharmacotherapy.

Kantor (1990) encouraged a two-illness model. He put forth the idea that some patients would be helped by considering that they suffered from character problems that would benefit from psychoanalysis and depressive illness that could be ameliorated by medication. He described a view of comorbidity in which one illness was psychological and in need of psychoanalysis or psychotherapy and one illness was deemed biological and in need of somatic treatment.

Although the two-illness model was itself an oversimplification, Kantor was attempting to deal with a reductionistic attitude on the part of many analysts who resisted embracing an integrative pluralism that would make it acceptable to turn to medication while engaging in analysis. Furthermore, he was highlighting a well-known clinical fact: Patients who are deeply depressed are unable to make use of what psychoanalysis has to offer, due to disruptions in ego functions. Pollock (1986) posited a similar two-illness model, when he asked, "Do multiple psychological diseases exist simultaneously?" He focused on the growing scientific literature supporting the genetic risk factors for bipolar disease and viewed this as evidence that a biological condition can exist alongside essentially neurotic symptomatology. Again, patients could be suffering from two illnesses simultaneously (biological and psychological), thus warranting two different approaches (medication and psychoanalysis).

*Advantages of a Two-Illness Model*

Contemporary models shy away from this kind of reductionism, but a two-illness model has certain values. Brain-to-mind causality and the legitimacy of alternative, nondynamic models of the mind become a part of the analyst's theorizing. Given the substantial comorbidity that exists in actual clinical practice for psychoanalysts and psychodynamic clinicians (Doidge et al., 2002; Friedman et al., 2005), this two-illness model remains helpful in guiding the clinician to consider the possibility that another illness that is not primarily psychological exists, which may benefit from medication.

Mr. A presented for treatment having relocated from another part of the country, where he was diagnosed and treated for recurrent manic episodes characterized by grandiosity, impulsive spending, and impaired judgment. He had become noncompliant with his lithium treatment after his first episode and soon thereafter suffered a relapse requiring hospitalization. By the time he came to treatment he expressed a clear awareness of the risk of recurrent illness, having "learned his lesson," and firmly believed that whatever was lost with regard to the pleasure of an elated mood was more than offset by not damaging the professional and personal areas of his life through his manic behavior. He acknowledged the genetic loading within his own family and felt that a biological explanation made sense. Over the subsequent decade, Mr. A would visit every 4 to 6 months as a way of monitoring his mood, checking his lithium level and thyroid functions. He consistently expressed the belief that lithium was a "lifesaver" for him.

However, he twice entered psychotherapy for a period of a year or so. In one instance, it was to discuss his frustrating relationship with his girlfriend, who was also his business partner. On a second occasion, it was to express his worries about his son, who as an adolescent had developed a substance-abuse problem and exhibited manic-type symptoms. In both periods of brief psychotherapy, narcissistic and dependent issues were a focus. In the first period, the psychiatrist explored how, on the one hand, Mr. A felt entitled to have more of a commitment from his girlfriend, while, on the other hand, his fears of dependency created a preference for a more aloof relationship. In the second instance, he needed help to make less use of denial so that he could mobilize on his son's behalf. The fact that he suffered from recurrent mania was relevant only insofar as the illness affected his self-esteem and dependency fears. The bipolar disorder itself was considered to be a biological illness effectively treated by his use of lithium carbonate.

*Disadvantages of a Two-Illness Model*

While the two-illness model is helpful in certain clinical situations, concealed within the model is a risky reductionism of its own. Insofar

as certain conditions are conceptualized as brain-based disorders that require somatic treatment, there is little room to consider psychotherapy or psychoanalysis unless a second illness (typically character pathology) is posited. Current research in combined treatment (Thase, 2003) indicates that the most robust findings for the efficacy of combined treatment are for the disorders most typically thought of as brain based (major depression, for example); that is, medication and psychotherapy combine to treat the one illness. While this research typically involves nonpsychodynamic psychotherapies, psychoanalysts often find psychodynamic exploration useful in treating such disorders.

Ms. B presented for treatment having seen a drug advertisement for the use of Zoloft (sertraline) to treat panic disorder that described its mechanism of action as "correcting a chemical imbalance." She described a long history of panic attacks with accompanying symptoms of agoraphobia. She had an enmeshed relationship with her mother that complicated her relationships with men, none of whom met her mother's standards. An intensification of her panic attacks was correlated with problems in her current relationship. The patient was disturbed by her anxiety symptoms, which left her with an imminent fear of death. Efforts to engage her introspectively were met with incredulity and defensiveness, with her asserting the legitimacy of her "chemical imbalance." The clinician, while suggesting a complex etiology for her symptoms, prescribed the desired drug, which markedly diminished her panic symptoms with much gratitude expressed by the patient; she continued to report little distress about her enmeshed relationship with her mother and even less motivation to explore her difficulties in sustaining a healthy relationship with a man.

This case illustrates how patients are at risk of seizing upon their need for medication as evidence of a brain disease without psychological cause or meaning. Some patients, however, are satisfied with relief of symptoms provided by medication and may not desire additional psychotherapeutic treatment for psychological problems.

We suggest that the discovery of comorbidity marks a starting point rather than an endpoint in the clinical decision-making process. In a recent effectiveness study of psychiatrist/analysts, Friedman, Garrison, Bucci, and Gorman (2005) found that 59% of patients treated in long-term psychotherapy/analysis had both Axis I and Axis II disorders, whereas only 11% had Axis II disorders alone. When comorbidity exists, the clinician needs to consider his approach to each condition as well as the interaction between or among the various conditions. One should not automatically assume that, because a condition is diagnosed on a given axis, by definition it requires drug therapy or psychotherapy. While the clinician has a stronger reason to consider medication for Axis I conditions, psychosocial interventions, including psychotherapy, are usually important for such patients. In addition, a psychodynamic perspective is helpful in dealing with the often conflictual experience of needing to take medication. The clinician who diagnoses a personality disorder will strongly consider the

role of psychotherapy or psychoanalysis while being mindful of the evolving literature on the role of medication in this population.

#### ON PHENOMENOLOGY AND EVIDENCE

Attempting to further advance consideration of the use of medication by psychoanalysts are the contributions of Roose, who, along with his many collaborators, has been an influential thinker within psychoanalysis on the subject of combined treatment (Cabaniss & Roose, 2005; Roose, 1990; Roose & Johannet, 1998). Roose discourages turning to theories of causality or etiology to inform treatment decisions. He suggests a rather strict phenomenological approach whereby the DSM-IV (American Psychiatric Association, 1994) is utilized to make a diagnosis and then clinical decision-making is determined, as much as possible, on evidence-based medical guidelines. He cautions the psychoanalyst against letting his theorizing blind him to alternative treatment perspectives for which evidence exists.

Whatever shortcomings might exist in utilizing this model (Swoiskin, 2001), the focus is on adopting a more scientific and evidence-based approach that would serve pragmatically to improve patient care. Roose is not interested in emphasizing brain-to-mind causality *per se*; he is trying to ensure adequate treatment for patients in analysis. These contributions serve as another wake-up call to psychoanalysts to consider somatic therapies.

In the last decade or so, evidence-based medicine (EBM), which proposes that clinical practice should be guided by the best possible evidence, has rapidly come to define an optimal standard of care (Deny, 1999). The gold standard for such evidence is the placebo-controlled randomized clinical trial. Evidence supporting the substantial acute and prophylactic effects of lithium carbonate for bipolar disease or the use of antidepressants in melancholia has proved convincing to most clinicians who readily integrate these findings into clinical decision-making. In general, the more robust the scientific evidence for the efficacy of certain treatments is, the more compelled the clinician is to consider those treatments in his treatment algorithm. This also means engaging the patient in the process of informed consent, especially if these treatments are not being pursued (Cabaniss & Roose, 2005).

While we believe that clinicians benefit from turning to the evidence derived from EBM, we are also aware of the risks and limitations of this approach. First, as Gabbard and Freedman (2006) recently pointed out, there are relatively few randomized, controlled trials of psychotherapy and, because of the requirements of manualization and standardization, such studies tend to differ from what goes on in clinical practice. Second, most studies tend to be brief (because of cost and practical considerations) and disorder specific, though patients typically present to clinicians with a more complex set of problems often tied to personality

traits (Zimmerman, Chelminski, & Posternak, 2005). Third, the combination treatment trials that do exist mostly involve cognitive-behavioral or interpersonal therapy, making extrapolations for the psychodynamic therapist speculative at best.

Because of these limitations, Gabbard (2005) notes the recent trend toward effectiveness trials that study treatments in a naturalistic setting, forgoing some of the rigors of efficacy trials (placebo control, for example). This kind of research can aid the clinician in answering a question of fundamental importance: Which therapeutic interventions are most helpful for which patient? Silverman (2005) also notes the potential limitations of a too strict adherence to a medical model for evaluating evidence in the clinical situation and reports the formation of a task force of the American Psychological Association to develop evidence-based guidelines for clinicians that will make use of process outcome studies, systematic case studies, and effectiveness studies.

In reviewing the empirical support for combination treatment, Thase (2003) asserts that, besides chronic or recurrent major depression, the evidence for combined treatment is best established for schizophrenia, obsessive-compulsive disorder, and bipolar disorder. He continues:

There is little evidence that psychotherapy-psychopharmacology combinations should be considered the standard of care for patients with milder depressive and anxiety disorders (the most prevalent conditions for which people seek treatment). The lack of additive effects may justify use of monotherapies first, based on availability and patient preference, with the alternative strategy used in sequence or in combination if necessary. (p. 138)

Hence, while EBM principles may beneficially be applied to some patients, a substantial number of patients will not present a clinical picture that will neatly fit an EBM treatment algorithm. Other considerations must be weighed. For the psychoanalyst, this will typically involve the generation of hypotheses about how psychic conflict has triggered an episode of illness and/or is expressed within the illness itself. When such hypotheses are developed in the evaluation phase, the clinician will consider the potential value of an exploratory treatment. The patient's preference is an important factor, particularly when alternative approaches are reasonable.

However, there will be times when a patient asserts a preference that may appear to the clinician to be suboptimal. In these instances additional psychoeducation may be valuable, but it may also need to be dealt with as a resistance. Among the factors to consider are character issues, intrapsychic conflicts involving the meaning of medication or psychotherapy, and disordered thinking that is related to the acute state of illness. A clinician who is receptive to the usefulness of various modalities of treatment and embraces a complex model of mental functioning is more likely to skillfully walk the line between respecting a patient's preferences while being attentive to potential defensive activity that can undermine optimizing care.

Mr. C, a middle-aged man, was referred by his internist, who was concerned that he was suicidal when he expressed the anxiety of crashing his car into trucks while driving on the highway and then imagining his death. On interview, Mr. C experienced this fantasy as highly disturbing and ego-dystonic. While not phobic about driving, he would display marked anxiety characterized by autonomic symptoms and a fear of losing control. The symptoms were most consistent with situationally bound (cued) panic attacks.

The therapist considered medication for these symptoms and discussed this option with the patient. Given his fears of being out of control, Mr. C preferred talk therapy over the use of medication or the combination, if possible. A dynamic psychotherapy was begun with the following considerations in mind: His capacity to function was not impaired; he did not have comorbid depressive symptoms and denied any suicidal intent; the precipitous onset of the symptoms together with recent and distant traumas noted later suggested a plausible dynamic hypothesis; and he was psychologically minded and motivated to talk.

Mr. C's anxiety began after witnessing a plane crash into the World Trade Center on 9/11. Part of the landing gear was outside his building as he exited. He knew several people who died in the attack. Earlier in his life, he had repeatedly been in the car with his father, who had a serious problem with alcohol. He recalled his father driving while intoxicated and also remembered driving his enraged, bleeding father to an emergency room after he cut himself fighting with Mr. C's mother. Among the various meanings of his symptom were:

- turning passive into active—reliving the trauma of 9/11—by imagining crashing his car into a truck as a plane had crashed into the towers
- identification with the aggressor—the trucks symbolized a threatening father and, by identification, the patient feared being out of control with his anger

A marked diminution of anxiety and an overall increased capacity to be assertive without fearing hurting others resulted from this exploration. For Mr. C, a psychodynamic approach was effective in resolving his anxiety about being out of control. In other patients, medication may be necessary to ease these symptoms. If a fear of medication causing loss of control exists, as it did for Mr. C, this concern may benefit from psychodynamic exploration.

#### THE DEVELOPMENT OF A COMPREHENSIVE THEORETICAL MODEL

Increasingly, psychoanalysts and psychiatrists recognize the need to consider the interaction between biological and psychological factors in

psychiatric disorders. Psychoanalysts will tend to see the continuities between a patient's character and symptomatic states that often benefit from medication. A growing literature within psychiatry similarly supports a shift away from a categorical approach to a dimensional perspective that links personality clusters as *forme frustes* to more serious illness (Siever & Davis, 1991).

For these reasons, a more complex conceptual and philosophical framework of the mind is necessary. To provide that, we turn to a recent contribution of Kendler (2005), who asks two major questions: How are mind and brain (inter) related and how can different explanatory views of mental illness be integrated? His propositions provide the clinician with a nuanced appreciation of complex mind–brain relationships and multiple causality. This is of foundational importance when considering the interaction of psychodynamic psychotherapy and medication. For this reason, we will highlight relevant aspects of his contribution in some detail.

Kendler asserts that Cartesian dualism, falsely dichotomizing mind and brain, must be abandoned. Affirming Damasio's central thesis in *Descartes' Error* (1994), he notes:

To reject Cartesian dualism (and accept monism, the view that mental and physical processes are both reflections of the same fundamental stuff) means to no longer consider the mental (or functional) to be a fundamentally different thing from the biological (or organic). Rather, the mental and the biological become different ways of viewing and/or different levels of analysis of the mind–brain system. (2005, p. 434)

However, dualistic thinking continues to infiltrate our approach to patients. As alluded to previously, clinicians may see psychiatric illnesses as “biological” and personality disorders as “psychological” (Roose & Johannet, 1998). We will argue that combined treatment, in most cases, benefits from viewing psychological treatments as also biological (Baxter et al., 1992; Kandel, 1979; Mayberg et al., 2002) and biological treatments as affecting the patient psychologically. This is not to say that psychotherapy and medication are the same or biological in the same way. Rather, it invites a more explicit exploration of how, given the fact that these are kinds of biological therapies, different approaches and pathways may be utilized to effect a favorable therapeutic outcome. Abandoning dualism, therefore, creates theoretical space for combined treatment.

Kendler extends his argument by proposing the acceptance of mind-to-brain causality and brain-to-mind causality. Despite the rejection of dualism, a distinction is made between those parts of the brain that are of central importance for mind (higher cortical regions, for example) and other regions that are more essentially bioregulatory (subcortical regions). Causality is a two-way street: Subjective experience (thoughts, feelings, fantasy, psychic conflict) has an impact on brain (and body) functioning and the brain affects subjective experience (mind). Bidirectional causality

is helpful when considering combined treatment in that it encourages the clinician to consider both brain-to-mind and mind-to-brain pathways for therapeutic aims. Psychotherapeutic interventions can be viewed as recruiting mind-to-brain pathways and drug therapy as recruiting brain-to-mind pathways. This view of causality illustrates how, while dualism is rejected, there are times when it is useful to conceptualize aspects of brain function as mind. Some phenomena (e.g., intentionality, fantasy) are best thought of in the language of mind, though they require a functioning brain.

Kendler views etiological processes as complex, overdetermined, and nonlinear, at least for major psychiatric illnesses. For example, genetic vulnerability is typically thought of as an “inside-the-skin” pathway. However, research supports the idea that genetic risk can actually gain expression through an “outside-the-skin” pathway. Specifically, genetic risk factors for major depression increase the probability of interpersonal and marital conflicts that are, in themselves, risk factors for major depression.

This kind of research illustrates the false dichotomy often expressed by a patient’s query: Is it my genes or the environment? An interactional model—one that acknowledges the complex relationship between environment and constitution—makes it less likely that the clinician will fall prey to oversimplification. While certain conditions have a very large genetic load (for example, the concordance rate for bipolar disorder in monozygotic twins approaches 0.9), what often determines onset of illness is not the presence or absence of a particular set of genes or certain environmental stressors but rather *a genetic or biological vulnerability that is either attenuated or unmasked by a given environmental stress* (Gabbard, 2005; Kandel, 1999; Suomi, 2003).

We suggest that, while Kendler was writing about a philosophical structure for psychiatry, his propositions provide a theoretically robust basis for considering combined treatment. By avoiding reductionism and dualism and by encouraging bidirectional causality and explanatory pluralism, the clinician is equipped to move into the consulting room better able to tolerate complexity and ambiguity and to consider therapeutic interventions through different causal pathways.

## INTERACTIONAL MODELS

Having provided a model of mind–brain relations and multiple causality, we proceed to heuristically useful interactional models for combined treatment that, by its very nature, are more complex than the two-illness model. Interaction can be conceptualized in a number of ways. One involves combining treatment—not to treat comorbidity, but rather to treat one condition by utilizing both “top-down” and “bottom-up” approaches.

The top-down pathway emphasizes mind-to-brain causality and a therapeutic approach that involves the mind of the patient who must actively engage his therapist through language, recruiting systems of meaning including wishes, fears, and fantasy. Relatively intact ego functions like working memory, concentration, and impulse control are required for a top-down intervention. On a neuroanatomic level, this approach acts through higher cortical areas and has a *downstream* effect on “lower” levels of brain functioning that are significantly involved in the clinical picture. The top-down pathway involves the patient as agent and implies the acceptance of intentional causality (i.e., the patient has some responsibility for his suffering as opposed to being stricken by illness), even if that causality is on an unconscious basis. Medication treatment is conceptualized as working through a bottom-up approach. In this view, drugs have a primary effect on subcortical areas of the brain that secondarily have an *upstream* effect on higher cortical centers.

With this model, one can visualize certain conditions as being most responsive to one approach or the other or can consider that a simultaneous *two-pronged approach* will be the most effective way to address a problem. The clinician is free to consider combined treatment as reflecting different pathways that can be recruited and then thoughtfully proceed to consider reasonable options with each particular patient. This can also help the clinician to assess the impact of a top-down versus a bottom-up approach. Are separate symptoms of a clinical picture being worked on or are the two approaches addressing the same symptoms through different but overlapping pathways?

Although not described in the top-down, bottom-up models, psychotherapy and medication may each affect both sets of pathways. For many mental disorders, there is a substantial placebo response rate that may act through top-down pathways. Additionally, current psychoanalytic theories emphasize the possible role of noninterpretive mechanisms of therapeutic action, which may affect subcortical areas—a bottom-up pathway.

Current neuroanatomic models of major psychiatric illness—clinical depression and panic disorder—utilize top-down and bottom-up approaches to describe the pathways to illness and health. Gorman, Kent, Sullivan, and Coplan (2000) put forth a neuroanatomic theory of panic disorder that takes into account both subcortical and cortical pathways. The amygdala, which is seen to be a crucial part of the fear network, is inhibited by both SSRIs and benzodiazepines. Bottom-up pathways involve the use of these drugs primarily to affect amygdala functioning and, secondarily, cortical functioning. Cognitive behavioral therapy and, more recently, psychodynamic treatment appear to be effective in treating panic disorder (Milrod et al., 2007); mobilizing systems of meaning and, in psychodynamic treatments, making the unconscious conscious may have a secondary downstream inhibitory effect on the subcortical fear network. Mayberg et al. (1999), Goldapple et al. (2004), and others have provided evidence for the importance of limbic and cortical systems in clinical

depression, also affirming differential top-down and bottom-up effects of psychotherapy and medication. The issue of combining treatment to treat anxiety and depressive illness will be dealt with explicitly in chapter 8.

*Metaphors: The “Magnet and Metal Filings” and “Resistance and Obstruction”*

Metaphors can assist us in conceptualizing complex interactions and developing a framework for thinking about the interrelationship between mind and brain. They also provide patients with a basis for understanding their experience. Gabbard (1992) has suggested one such metaphor: He has likened the tension between psychological and biological causes to the relationship between a magnet and metal filings. This metaphor is meant to convey how a biological diathesis can function as a magnet—an organizer or attractor—for psychic experience; the phenomenological expression of essential conflicts takes shape through the experience of the biological diathesis. However, at times it can be helpful to consider the metaphor in reverse. A primary psychological conflict can function as the magnet activating an otherwise weak biological diathesis (i.e., the metal filings) to gain expression. The resolution of the psychological conflict as magnet then relieves the patient of the biological diathesis that has been unmasked.

Mr. D, a 30-year-old man working as a technician in a radiology department of a hospital, was hospitalized when he relapsed into a mixed bipolar state with psychotic features. On several occasions he ran about the ward naked, experiencing high sexual desire while thinking he was possessed by the devil. He had “visions” that he would be cut up into pieces. He was a virgin who lived at home with his elderly mother; the latter slept in the same room as him, a behavior rationalized out of worry that he would not sleep. He feared that his mother would not let him back into the house because he was evil. A readjustment in his medication (carbamazepine and olanzapine) brought about a resolution of his psychosis.

In this vignette, the mixed psychotic and affective state is regarded as a biological magnet that organizes the metal filings of core psychological conflicts around separation, sexuality, and punishment in a highly primitive and terrifying way.

Ms. E, a young woman in analysis with a history of low grade depression and generalized anxiety, developed, for the first time, an obsessional symptom while in analysis as she anticipated the analyst’s August vacation. The symptom was an ego-dystonic intrusive thought that she had feces in her mouth. Analysis of the symptom within the transference, particularly her feeling of being devalued and worthless because the analyst was going away, rekindling feelings of abandonment when her father left when she was a child, freed her up to express her anger toward the analyst in a way that felt safe, leading to the resolution of the symptom.

In this vignette, the psychic conflict was the magnet, which recruited a weak biological diathesis for obsessive–compulsive disorder. The symptom resolved with analysis.

Often it can be difficult to tell whether biology is the magnet organizing psychology, vice versa, or both. We are left generating hypotheses that we inevitably test in the clinical situation and constantly evaluate the goodness of fit. Probably the most common way this operates is with the patient who presents with significant mood disorder and character pathology (discussed further in chapter 9). The following is an example of hypothesis testing as it relates to a man with ADHD.

A doctoral student in the neurosciences (previously reported in Sandberg, 1998) presented with anxiety and insomnia while pursuing a competitive academic degree and had an impoverished history of intimate relationships. His early history was significant for a frequently absent father who was also less educated. The patient had surgery for an undescended testicle as a young child. The early formulation of an oedipal level conflict manifesting itself as an inhibition gave way to a new formulation when the patient, free associating to his early childhood experience, told the therapist of a previously concealed piece of his early history. He had been formally tested and diagnosed with ADHD in childhood, and this deficit (concealed for narcissistic reasons in the consultation phase) had interfered with his ability to focus on his studies, an area of interest (brain science) no doubt influenced by his awareness of his deficit.

This specific information surfaced while the clinician was exploring a dynamic hypothesis. The patient had been encouraged to free associate to his early experience in school after speaking about missing his father, who was frequently away. A dynamic model had motivated the clinician's inquiry, which then brought up new data that resulted in a reformulation of the case material. What phenomenologically looked like a primary psychological conflict that would benefit from psychotherapy was reassessed and managed with a trial of stimulants that, for this patient, facilitated not only a productive and increasingly efficient way of working but also the time and energy to become romantically involved and subsequently married. In this case, the biological diathesis was the ADHD state (the magnet) around which the psychological "metal filings" of oedipal conflicts revealed itself. The stimulant resolved both states, though another patient with similar symptoms may have required further psychological help.

Wylie and Wylie (1995) introduced another metaphor for conceptualizing the issue of psychological and biological interaction: the notion of "obstruction," as distinct from resistance, to reflect the core constitutional and/or hereditary factors that impede the progress of psychotherapy or psychoanalysis because they must be modified by medication. If the obstruction is not dealt with pharmacologically, the analytic process cannot proceed. They make an explicit suggestion: Therapists need to consider that a clinical situation marked by tenacious resistances may be obstructed by a biologically based disorder that is unmedicated:

What occurs when the patient inevitably wraps unconscious meaning around the experience of his or her neurobiological factor, is that the nonpsychological factor becomes embedded in the patient's dynamic resistance, and nidus like accrues more defensive strength. It is this nidus which obdurately refuses to yield to analytic efforts, precisely because it is non-psychological in origin. (p. 191)

The clinician is also at risk for wrapping unconscious meaning around the experience of a neurobiological factor. To use Gabbard's metaphor, this is an example where the metal filings are confused with the magnet because the magnet is not seen as present. Persistent resistance becomes a clue to step back and consider the presence of a second illness that creates an obstruction in the psychotherapeutic process.

#### BIMODAL RELATEDNESS

The clinician's evaluation of both biological and psychological etiologies of psychiatric illness is experienced internally as an oscillation between different frames of reference that will encourage an interpretive focus that emphasizes the patient's subjectivity or the introduction of medication. Cabaniss (1998) describes this oscillation as "shifting gears" between these different perspectives and evidence. Sandberg (1998) elaborates on the idea of "bimodal relatedness" (Docherty, Marder, Van Kammen, & Siris, 1977), which is the interpersonal manifestation of shifting gears; that is, it expresses the distinction between being with a patient (with what Freud described as free floating attention) and acting on a patient with medication.

Combined treatment, by definition, involves these differing ways of relating. At times, shifting gears will feel comfortable, offering patient and therapist additional therapeutic leverage that works additively or synergistically. At other times, these different treatment approaches may feel contradictory or antagonistic. These tensions will be elaborated throughout this book. Perhaps it is Jackson (1992) who, in an article on the listening healer, has put it most eloquently:

The place of listening in depth and with empathy is a crucial element in healing. While the emphasis on looking remains significant in the gathering and appraisal of data, at times it threatens to overwhelm the need for an attentive and concerned listener. There appears to be a natural tension between the two modes that has, in modern times, been translated into a tension between a scientific mode of gathering information and a humanistic mode of knowing sufferers. A healer neglects either one at his or her peril—and at the peril of his or her patients. (p. 1632)

## CONCLUSION

In this chapter, we have attempted to provide an overview of the essential and complex theoretical issues that relate to combined treatment for the psychodynamic therapist and psychoanalyst. While current trends within psychoanalysis emphasize a relational perspective, man's corporeal nature reasserts itself when the use of medication is considered. We have observed that psychoanalytic theory has its roots in a biological or somatic basis; clinicians of all theoretical persuasions must maintain the legitimacy of this point of view. We have attempted to elucidate various ways in which clinicians can accomplish that.

We have outlined the evolution in theorizing about combined treatment from a rudimentary two-illness model to more complex interactional models. The two-illness model evolved as a response to the growing wealth of knowledge within biological psychiatry that included genetic studies, brain scan data, and drug studies. It also should be seen as a response to an underlying antagonism by many dynamically and analytically oriented clinicians toward the use of medication. As a corrective, particularly within psychoanalysis, it has served its purpose well, as evidenced by the significant number of analytic patients who now receive medication. In addition, there are some patients with severe mental illness who are well managed by thinking of their illness as biologically determined and medication responsive. We also noted that the two-illness perspective, if rigidly held, could create a reductionism of its own.

We observed that another significant trend within psychoanalysis involved utilizing a phenomenological approach based on the DSM-IV (American Psychiatric Association, 1994) and evidence-based medicine, which served to advance the use of medication for patients in analysis. At the same time, the EBM perspective has important limitations, given the fact that patients in clinical practice often present with a constellation of symptoms that are more complex than those researched.

Having described the potential limits of a two-illness model and evidence-based medicine guidelines, we provided a more overarching theory of mind that provides flexibility while addressing greater complexity. An abandonment of mind-brain duality, the avoidance of reductionism (whether biological or mentalist), and the consideration of bidirectional mind and brain causality are all essential aspects of a contemporary view of mind that can accommodate the place for combined treatment. Combined treatment approaches can usefully be conceptualized through "top-down/bottom-up" models and the use of metaphor.

At times, a psychological state will be viewed as triggering a biologically based illness; in other instances, a medication-responsive syndrome will be seen as intensifying psychological conflict. These reflect only two of the numbers of ways to consider interactional dynamics. As the clinician considers these and other possibilities, he tests his hypotheses in his mind and with his patient, making the best use of the various kinds of

evidence he has available to him. This process of oscillation among different frames of reference will be illustrated throughout the remainder of the book and is always present when getting started—the focus of chapter 3.