THE PSYCHOLOGICAL IMPACT OF COMBINED TREATMENT: WHEN THE PSYCHOPHARMACOLOGIST JOINS THE PSYCHOANALYTIC PSYCHOTHERAPIST

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A dissertation submitted to the
California Institute for Clinical Social Work
In partial fulfillment of the requirements
For the degree of Doctor of Philosophy
In Clinical Social Work

By

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June 1, 2000

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CALIFORNIA INSTITUTE FOR CLINICAL SOCIAL WORK

DISSERTATION APPROVAL PAGE

We hereby approve the dissertation

Psychological Impact of Combined Treatment;
When the Psychopharmacologist Joins
The Psychoanalytic Psychotherapist

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ABSTRACT

The Psychological Impact of Combined Treatment;
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This qualitative study explored the therapist's perception of the impact that the introduction of the psychopharmacologist had on the relationship between the patient and the therapist in an ongoing psychoanalytic psychotherapy. It describes the way in which six therapists came to think about a referral, how they felt when the referral was made, the necessity of a good working relationship, and the potential reparative aspect of the triangular relationship.

Four main themes came out of this study, each with three or four categories. The first theme was that of is anything happening here with its categories of intractable depression, impenetrable anxiety, the patient needing an emotional floor, and feeling stuck. The second theme was the parental couple with the categories of repair, re-enactment, and splitting. The third theme, therapists' inner process, had the categories of relief, collaboration, and self-worth. The fourth theme was working relationship with the categories of boundaries, respect, and communication.

The study found for those patients who need medication, referral can be a positive experience for the therapist and the patient rather than being considered a "failure." Each therapist has a unique, individual connection with his or her patient, and these two have

an equally unique and individual relationship with the specific psychopharmacologist chosen for consultation.

Dedication

This dissertation is dedicated with much love and deep gratitude to
"My Psychological Parental Couple"
Dr. Nancy Carolyn Wood and Dr. Linda L. Lasater
whose patience, persistence, love, depth, and lack of fear have
allowed for my psychological development,
growth, and balance....

Acknowledgements

I owe a deep thanks to all of the CICSW Community and all of those who have touched my life helping to make this achievement possible. There are some people to whom I owe special thanks.

First, I would like to thank my committee members. Dr. Gareth Hill, Dean of Students. Dr. Diana Miller, my external committee member and dear friend. Dr. William Dombrowski, my research committee member and teacher, who has consistently believed in my ability to do this and who has given generously of his time. Dr. Alexis Selwood, Chairperson, mentor, friend, confidant, guide, teacher, editor. Your warmth, tenacity, patience, and belief in me, plus the immeasurable time you have given me, has meant a great deal.

I also want to thank Dr. Elinor Grayer, my colloquium leader; Dr. Rebecca Jacobson, my first CCF; and Maggie Magee, my second CCF, consultant, and valued friend. Dr. Steven Portuges for reading my proposal, and Tina Cazanza for her administrative assistance. I want to thank Dr. Judith Schore for her technical assistance and for her enthusiasm. Lee Freehling, MLS and Dawn Saunders, MLS for making library researching so much fun; Roz Harrison and Monica Koga for their editorial, secretarial, and transcription services; and especially Terrie Barna for her editorial assistance and energy.

I also extend thanks to my neighbors, friends, and colleagues; the Rappaports, and to their lovely, accomplished daughter, Andrea. To Nathaniel and Zachery for letting me share so much with them, and to Dr. Robert Gerstein, whom I can always count on. To Dr. Lewis Engel for teaching me almost everything I know about psychopharmacology and for being such a consistently caring person in my life.

I would like to thank all of the members of the Los Angeles Chapter of the Committee for Psychoanalysis in Social Work who gave of their time for this project, and in particular the nine therapists who gave of their time to be interviewed. You made this study possible. I would like to extend a special thanks to my long time friend Dr. Jane Rubin-Gerstein, who is always there; and to Dr. Ellen Ruderman, the first professional role model I had, I say thank you.

I would like to particularly thank Susan Spiegel and Jill Horowitz for their friendship, and of course Dr. Sandra Thomas, my fellow graduate, who has been my right hand since beginning this program. Without Sandra I'm not sure I would have made it through the last four years, and certainly not as intact. Sandra and I began this journey together and we end it together. We have laughed and cried and e-mailed endlessly. We've had Friday night dinners and roomed together, but most importantly, she has taught me much about life, tolerance, and friendship. It is with love and appreciation that I say thank you, Sandra.

Finally, I say thank you to my "family," that rich circle of friends who surround my life adding meaning and love to my existence every day. To Lucas Allen, who showed me the miracle of birth, and to Robin and John for their continual assistance with any and all of my needs. To Doug, who keeps my sense of humor alive while at the same time keeping me politically on my toes. To Alice, who by teaching me tennis, taught me that I could do just about anything I tried. She's also the best sister/friend a girl could ever have. To dear Vicki for being "uniquely" you and for always being so loving and supportive of me. To Michele, who was the first adolescent who let me put my psychological knowledge to use in reality, and to Luis for his love of the unconscious and his love of me. To Sierra and Bayla, who have taught me about love, connection, and attachment on a whole new dimension. They enrich my life immeasurably and make it all worthwhile.

TABLE OF CONTENTS

CHAPTER I INTRODUCTION 1

Psychoanalytic Attitudes About Medication 1

Introduction to the Theoretical Context 4

Theoretical Framework 5

Transference and Countertransference 6

Statement of the Problem 8

Purpose of the Study 9

Research Design and Questions 10

Significance of the Study 11

CHAPTER II REVIEW OF THE LITERATURE 13

Combined Psychotherapy-Psychopharmacology 14

Effects of Combining Psychotherapy and Psychopharmacology 17

Positive Aspects of Combined Treatment 17

Negative Aspects of Combined Treatment 18

The Therapeutic Triangle 18

The Therapeutic Relationship 21

Transference Reactions 22

Countertransference Reactions 27

Collaboration Between Two Practitioners 28

Conclusion 30

CHAPTER III METHODOLOGY AND PROCEDURES....31
Design of the Study....31
Procedures for the Selections of Subjects....32
Data Collection....34
Interview Guide....35
Protection of Human Subjects....37
Data Analysis....38

CHAPTER IV FINDINGS....40
Review of Methodology....40
Demographic Information....42
Themes and Categories....43
Theme 1: Is Anything Happening Here?....43
Category 1: Intractable Depression....45
Category 2: Impenetrable Anxiety....47
Category 3: Patient Needing An Emotional Floor....48
Category 4: Feeling Stuck....49
Theme 2: Parental Couple....52
Category 1: Repair....53
Category 2: Re-enactment....56
Category 3: Splitting....59
Theme 3: Therapists' Inner Process....61
Category 1: Relief....62
Category 2: Feelings About Collaboration....63

Category 3: Feelings of Self-Worth 64
Theme 4: Working Relationship 66
Category 1: Boundaries 67
Category 2: Communication 68
Category 3: Respect 69
Summary 70

CHAPTER V DISCUSSION 72
Review of Findings 73
Theme 1: Is Anything Going On Here? 73
Theme 2: Parental Couple 77
Theme 3: Therapists' Inner Process 81
Theme 4: Working Relationship 82
Implications for Clinical Social Work 83
Limitations of the Study 85
Recommendations for Further Research 86
Conclusions 87
Appendixes 89
Appendix A. Introductory Letter 90
Appendix B. Pre-Interview Questionnaire 92
Appendix C. Therapists' Informed Consent 94
Appendix D. Interview Guide 96
Bibliography 99

CHAPTER 1

INTRODUCTION

In the past two decades psychotropic medication has been increasingly combined with long term psychoanalytic psychotherapy. Originally, medications were combined primarily with interpersonal, cognitive or supportive psychotherapy rather than psychoanalytic psychotherapy (Knowlton, 1997). More recently, many psychoanalytic authors (Kahn, 1993; Kantor, 1993) have concluded that medication combined with analytic psychotherapeutic work may have multiple beneficial effects. Now evidence can be readily found as to the effectiveness of both medication and psychotherapy in relieving many disorders (Racy, 1995).

This change in thinking has raised three major areas of concern for psychotherapists who have been trained in psychoanalytic psychotherapy. The first concern is how the therapist thinks about various aspects of a patient's difficulties and decides which may be caused by biological conditions and which may be caused by psychological conditions. The second area is the impact that the introduction of a third person, the psychopharmacologist, has on the transference and the countertransference. The third area concerns the changes that need to be made within the psychotherapeutic relationship once the psychopharmacologist has become part of the treatment situation.

Psychoanalytic Attitudes about Medication

It was believed that psychoanalytic psychotherapy was a "deep" and "curative" method of treatment in and of itself. Medication was not only considered unnecessary,

but it was also seen as an undesirable intrusion into the analytic situation that fed a patient's fantasies for quick, simple solutions to deep intrapsychic issues (Bradley, 1990; Gutheil, 1993; Kahn, 1990; Karasu, 1993; Schuman, 1992). It was the undisturbed analytic dyad that was believed to be the curative factor in analytic work. This bias existed even though Freud (1938) himself, the father of psychoanalysis, appeared to recognize the need for medication when he wrote the following:

> The future may teach us how to exercise a direct influence, by means of a particular chemical substance, upon the amounts of energy and the distribution in the apparatus of the mind. It may be that there are other still undreamt of possibilities of therapy. (p. 182)

Even though Freud seemed to recognize the importance of understanding biological and constitutional factors, many psychoanalytically oriented clinicians tended to minimize the role biological factors played in emotional equilibrium and well-being. From this perspective, psychological distortion was considered to be the "real" cause of mental and emotional problems. On the other hand, psychopharmacologists, who believed that underlying neurochemical imbalances were the root of the problem, tended to minimize psychological causation even if they did think some minor neurotic disturbances were treatable with talking therapy alone (Schuman, 1992). For the patients who were experiencing distress emanating from both planes, this antagonism, when it existed between the analytic therapist and the psychopharmacologist, could be quite unsettling and cause additional emotional conflicts, which would then interfere with treatment.

The wide array of newer, lower side effect medications that have been developed within the last two decades have opened up a range of psychopharmacological possibilities. Knowledge about the effectiveness of these newer medications has allowed

psychoanalytically oriented psychotherapists to consider a biological, as well as a psychological, understanding of human behavior, thoughts, and affects.

Roose and Johannet (1998) have observed that patients, therapists, and psychopharmacologists have found an effective treatment often does more than simply treat the illness. It changes the person (p. 620). Referring to Winnicott's description of the "holding environment," Hoffman (1990) says that if we conceptualize biological intervention as a system of meaningful interactions with a patient or a holding environment, then biological intervention can then be incorporated within the framework of dynamic/analytic psychotherapy (p. 371). It is important for us to remember that all psychological disturbance occurs in the context of a mind/body connection, and that both must be addressed when necessary or indicated.

Reminding us of Winnicott's adage that there is no such thing as a baby without a mother, Schuman (1992) speculates that there is no such a thing as a drug independent of the relationship in which it is prescribed (p. 1). This idea states quite definitively the purpose of this study, i.e., to understand the relationship between the patient and the therapist and all that happens to this relationship when a third person is introduced to medicate the patient.

There is, of course, still conflict in the psychoanalytic community about combining medication with ongoing psychoanalytic psychotherapy. Gutheil (1993) describes this when he speaks of the various transference and countertransference complications that can occur when medication is introduced into the treatment situation. Perhaps the hesitation to use medication is due to the fact that there is still very little

known about the process that occurs when medication is introduced into an ongoing psychoanalytic psychotherapy.

The idea for this study grew out of this researcher's interest in the positive impact some of the newer psychotropic medications had on her own and her colleagues' patients. Some of the patients who had been in intensive psychoanalytic treatment for many years improved dramatically in a way they had not been able to do with psychotherapy alone. With the addition of medication they were able to use psychotherapy in a much more effective way. These observations raised questions in the mind of the researcher about the introduction of the psychopharmacologist into the treatment situation. These questions led to the formulation of this study, in which the impact of the medication itself is not being looked at, but rather the impact that the introduction of the psychopharmacologist has on the treatment relationship.

In summary, this researcher is particularly interested in three major areas: How the therapist thinks about the interplay of the psychological and biological aspects of the patient's difficulties. What is the therapist's perception of the impact that the introduction of the psychopharmacologist has on the therapeutic process, especially the transference and countertransference? How does the therapist change his/her approach toward the patient or the therapy once the psychopharmacologist has been introduced into the treatment situation?

Introduction to the Theoretical Context

Psychoanalytic psychotherapy is a style or technique that emerged out of psychoanalysis due to the more disturbed population of patients that were/are presenting

in therapists' consulting rooms. It was originally believed (Freud, 1958) that only neurotic patients were suitable for psychoanalysis. Today, however, with broader thinking, theoretically (Kernberg, 1980; Kohut, 1971; Segal, 1964; Stolorow, 1994; Winnicott, 1972; etc.), most all-diagnostic categories are now seen as treatable with psychoanalytic psychotherapy. Mood Disorders, Anxiety Disorders, Somataform Disorders are all now seen as treatable with psychotherapy/drug combination treatment (Cabaniss, 1998; Knowlton, 1997; Milrod & Busch, 1998; Normand & Bluestone, 1985; Racy, 1995; Roose & Johannet, 1998).

Theoretical Framework

Psychoanalytic therapy consists of a core commitment to a sustained, collaborative inquiry into the complex textures of human experience. The experience established in the interplay between past and present, actuality and fantasy, self and other, internal and external, conscious and unconscious, as all are exemplified and demonstrated through the transference and countertransference (Mitchell & Black, 1995).

Psychoanalytic psychotherapy is defined as a treatment that focuses on transference and countertransference for those patients who were once thought to be untreatable by classical psychoanalysis itself and for those who do not desire or could not afford psychoanalysis (Wallerstein, 1995). Many of these patients have not been referred for medication in addition to psychotherapy until recently due to biases in analytic thinking.

Psychoanalytic psychotherapy is differentiated from other therapeutic models such as behavior therapy, medication therapy, cognitive therapy, hypnotherapy,

supportive therapy and many others, because of its attention to the transference and countertransference. Many of these other therapies work in the here and now rather than going back into the past and focusing on early developmental conflicts or developmental arrests. They are not based on the belief as is psychoanalytic psychotherapy that unresolved issues from our early lives prevent us from moving forward effectively as adults.

Transference and Countertransference

In the 1970s, psychoanalytic psychotherapy was introduced (Langs, 1973) as a newer style of therapy that would allow more patients to get the help they needed. It allowed for a broader array of diagnostic categories to be treated than had the more rigid form of psychoanalysis that it grew out of. Psychoanalytic psychotherapy was a growing, evolving theory that expanded the view and scope of psychoanalytic treatment. Starting with Freud, transference was defined as those responses to the therapist that are primarily based on or displaced from significant childhood figures (Greenson, 1967). Klein broadened the definition of transference to include all that goes on in the relationship between the patient and the therapist. All interactions are seen and understood as transference representations of primitive internal states (Joseph, 1997). The Object Relations theorists such as Guntrip, Fairbairn, Winnicott, etc., began to broaden the definition of transference even further and were eventually aided by the Self Psychological and Intersubjective perspectives. Transference came to be seen as part of a therapeutic process that is viewed as relational, one that involves both the therapist and the patient as equal participants (Schwaber, 1985).

Langs (1974) defined countertransference as one aspect of the therapist's response to the patient, which, while prompted by some event within the therapy or in the therapist's real life, is primarily based on his past significant relationships. The therapist gratifies his/her needs rather than the patient's therapeutic endeavors. The therapist's countertransference reactions are based on unconscious fantasies and memories, and they may be conscious or unconscious. More contemporary uses of countertransference (Segal 1964; Stewart, 1992; Stolorow, Atwood, & Brandchaft, 1994; etc.) are seen as more complex and in-depth ways of understanding what may be going on in the patient's inner world through the therapist's understanding of his/her own internal reactions.

Gill (1979) believes that all aspects of the analytic situation are contributed to by both parties, but to different degrees. This idea is reflective of more present day analytic thinking where the relationship between the patient and the therapist and the consideration of the input of both parties is thought to be crucial. From this perspective, when a psychopharmacologist is introduced into an ongoing psychoanalytic psychotherapy, his/her presence would also contribute to the analytic relationship impacting both the transference and the countertransference.

David Phillips (1993) talks about the relationship becoming a therapeutic modality in and of itself. This is because the relationship is no longer seen solely as the vehicle through which interpretation is made, but rather the relationship itself is seen as the medium through which change takes place.

While therapists from different theoretical backgrounds view the relationship or therapeutic connection differently, almost all therapists today would agree that what goes

on between the patient and the therapist is a representation not only of past dramas being reenacted, but of a real relationship between two people as well.

The focus of this study was not on psychoanalytic theory or definitions of transference and countertransference, but rather on the process that occurs when a psychopharmacologist is introduced into an ongoing psychoanalytic psychotherapy. The study focused on the therapist's own understanding of the transference and countertransference, and the therapist's perception of any changes that occurred in the two that were seen as influencing the way the therapist handled the therapeutic process once the psychopharmacologist was introduced into the treatment situation. Therefore, this study used the participating therapists' own theoretical understanding and definitions rather than attempting to fit their understandings to any specific existing theory.

Statement of the Problem

As discussed above, the psychoanalytic community has traditionally had a negative attitude toward the use of psychotropic medication during psychoanalytic psychotherapy. This has been very harmful to patients who have been in need of analytic psychotherapy and medication. Although there is still some controversy about integrating medication and psychoanalytic psychotherapy today, this researcher and many others in the clinical field believe it is necessary. There is still very little knowledge about how therapists think about what is biological and what is psychological and what happens to the transference and countertransference when a third person is introduced into the formerly dyadic therapeutic relationship. This information is extremely necessary today because there are large numbers of patients requiring and/or requesting medication as

well as psychotherapy. How the therapist thinks about which aspects of the patient's difficulties are psychological and which are biological, makes a difference in the treatment outcome. Likewise, how the therapist handles the introduction of the psychopharmacologist, and how the therapist handles the therapeutic process after the psychopharmacologist becomes a part of the treatment relationship makes a difference. Therefore, we need to know more about these issues.

Medication recommendation involving a third party is a complicated decision that carries the potential to activate complex interpersonal issues for the patient, the therapist, and the psychopharmacologist. At this point in time, some research literature has been devoted to the combination of drug treatment with psychoanalysis and supportive psychotherapy. Transference, both negative and positive, as well as countertransference and splitting, are mentioned in the literature and will be discussed in Chapter II. However, little if any attention has been devoted to the three areas on which this study has focused.

Purpose of the Study

The present study was designed to explore the therapist's perception of the impact that the introduction of the psychopharmacologist has on the therapeutic relationship. This study aimed to understand how the therapist thought about various aspects of the patient's difficulties, those seen as psychological and biological at the point of referral, and how the therapist handled the therapeutic process after the psychopharmacologist became a part of the treatment relationship.

This study was necessary because, to date, there are no studies that look at what happens to the therapeutic relationship when a psychopharmacologist enters the mix. Additionally, because of the large numbers of patients who are now being seen that either need or request medication in combination with psychoanalytic psychotherapy, this type of study and information is relevant to help guide therapists when they initiate work with a psychopharmacologist. It may help to illuminate some of the pitfalls and challenges that a therapist faces when confronted with making a medication referral, and it may help prevent disastrous outcomes for patients that, with thought, understanding, and study, can be avoided.

This study has been a beginning exploration that will hopefully raise questions for further research.

Research Design and Questions

The research design was a qualitative one involving therapists' recollections of cases toward reconstructing their own processes in making assessments and decisions in the treatments.

Qualitative designs can be very useful for evaluating situations that emphasize individualized outcomes such as patient or therapist responses to specific phenomenon. Creswell (1994) talks about how in qualitative studies the research problem is one being explored because little exists currently in the area of proposed study. Strauss and Corbin (1990) remind us that qualitative methods can give intricate details of phenomena that are difficult to convey with quantitative methods.

In this study therapists were interviewed about their perceptions and observations as they relate to the therapeutic relationship after a medication referral was made. It was suggested to participants that they pick a particular patient with whom they had worked where they made a medication referral, thus, bringing a psychopharmacologist into their treatment relationship with the patient. They were asked to talk as freely and elaborately as possible about how they thought about the interplay of the psychological and the biological aspects of their patients' difficulties both before and after a referral for medication was made. They were asked to describe their perception of the impact that the introduction of the psychopharmacologist had on the therapeutic process, especially the transference and countertransference. They were also asked how they changed their therapeutic approach and/or style with this particular patient once the psychopharmacologist was introduced into the treatment situation. How they understood that which they saw as biological and that which they saw as psychological was also of particular interest. The participant was directed to think about and reflect on all these situations from the point at which the therapist started thinking about medication, through to the point when the patient was on medication and some effect on the relationship due to the therapeutic triangle was noticed.

Significance of the Study

The potential significance of this study emanated from the idea that all psychic imbalances are made up of a duality of mind and body. Today in contemporary psychoanalytic work as this idea becomes increasingly accepted, more and more treatment relationships are triangular consisting of a psychotherapist, a

psychopharmacologist, and a patient. This study, therefore, offered an opportunity to look in depth at the psychological impact of these combined treatment relationships.

This study also may help further research in that it may provide deeper, richer material to look at and understand than had previously existed. As Patton (1990) states, "Qualitative methods typically produce a wealth of detailed data about a much smaller number of people and cases" (p. 165). Information-rich cases allow us to learn a great deal about what issues are of central importance and what is ripe for further study and/or investigation. Additionally, this study shows us how these therapists struggled with differentiating between what is biological and what is psychological, as well as how they dealt with the changing transference and countertransference issues.

CHAPTER II

REVIEW OF THE LITERATURE

This chapter will briefly review the history of the integration of psychopharmacology and psychoanalytic psychotherapy. It will begin with the early opposition to integrated and triangular treatment relationships, then it will move onto more recent writings that support the benefits and advantages of these combined treatment relationships. The chapter will include the various aspects of combined treatment that can impact the therapeutic relationship. These include transference, countertransference, splitting, and collaboration between professionals and common patient reactions to a medication recommendation. The chapter will conclude with a brief overview that relates the literature to the researcher's own thinking on this subject.

Freud recognized the role of biology in human experience and pathology. Subsequent generations of practitioners failed to share his openness. This has led to a polarization between the somatic therapies and the psychotherapies (Gutheil, 1993). Traditionally, the attitude towards the use of psychotropic medication in psychoanalytically oriented treatment has been negative (Roose & Stern, 1995). Many psychoanalytic practitioners, while not denying the role of biology, have certainly minimized its importance.

The "real" causes of patients' problems were seen as psychological in nature. The 1950s saw the beginning of the biological revolution and biological psychiatrists, who saw most phenomena as a result of chemical imbalances. They held little regard for psychotherapeutic interventions or explanations of behavior that were purely

psychological (Bradley, 1990; Knowlton, 1997; Schuman, 1992). In the late 1960s, the community mental health movement emerged with its public health orientation and nonhierarchical, egalitarian ideology. This movement saw non-physician therapists as equal partners with psychopharmacologists in the psychotherapeutic field (Meyer, 1999). More recently, psychoanalytic psychotherapists have begun to combine medication with analytic therapy when necessary.

Combined Psychotherapy-Psychopharmacology

Langs (1974) spoke of psychodynamic or psychoanalytic psychotherapy as "beginning with a relationship between two people, a patient who is seeking help for some kind of emotional suffering, and a therapist who is competent to offer this kind of help" (p. 146). He goes on to state that "characteristics of the patient–therapist relationship have distinctive attributes that are influenced by the personality and psychopathology of both parties" (p. 150). These individual qualities relate to the way in which the particular patient's relationship will develop with the therapist, and this will significantly impact the nature of the transference, just as the therapist's own history and personality will affect the countertransference. Which defenses a patient uses will also develop out of these individual variables that exist between a patient and his/her therapist. Lang's thoughts underscore the importance of the therapist's attunement to the patient. The findings of this study address the use of the term "relationship" and its impact on the patient-therapist dyad when therapy is combined. Psychopharmacology is drug therapy aimed at treating, diminishing, and controlling symptoms of major psychiatric illnesses

(Bradley, 1990). It is only recently that these two modalities have been integrated, particularly in psychoanalytically oriented psychotherapy.

Combined treatment, also called split treatment or triangular treatment, involves both a psychiatrist and a non-medical therapist (psychologist, social worker, nurse, or marriage and family counselor). The psychiatrist prescribes medication, and the non-medical therapist provides psychotherapy for the same patient. (Goldsmith, Paris, Riba, Balon, 1999). For purposes of this study, the words "combined," "split," and "triangular" will be used interchangeably.

Sawer-Foner (1960) was the first to publish findings from a conference relating to combined treatment. He reported that analytic treatment was the only one that was held effective for severe illness. Medication was seen at this point as capable only of treating symptoms that would clarify the transference and therefore allow more effective psychotherapeutic work to take place.

Ostow (1962) was the one who truly pioneered the use of combined therapy. He elaborated on the concept that drugs helped patients to tolerate the therapeutic process, but also warned those drugs could lead to premature termination. Kahn (1993), in reviewing research in combined treatment, concluded that drugs and psychotherapy work on different aspects of patients' disorders. Psychotherapy seems to be most helpful in social functioning and repairing past emotional deprivation, while medication seems most helpful in treating dysfunctions of mood and thought content. Karasu (1982) suggested that psychotherapy helps chronic traits; medication treats more acute symptoms. Myerson (1982) differentiated between neurobiologic symptoms that a person "can't

change" and that require medication, and basic resistance that "won't change," but can be treated psychotherapeutically.

Adelman (1985) and Klerman et al. (1984) proposed a "biosocial" model of illness. This model assumes that all diseases have biological, psychological, and social factors that influence the development and progression of disease. Current research and theory suggest that biological, psychological, and social factors are mutually interactive and that they can influence the development of psychiatric disorders (Klerman, 1991).

It has been known for some time that pharmacological interventions are effective for a variety of mental disorders, and there is a growing belief that psychotherapeutic interventions may also be as effective for these disorders (Eysenck, 1952; Klein, Gittleman-Klein, 1976).

An oft-quoted contribution by Klerman et al. (1984) concludes that there is no negative interaction between psychotherapy and psychopharmacology. In fact, their studies showed that a combination of the two modalities was more effective than either modality alone. Gabbard (1994) writes the time has come to acknowledge that patients often have disturbances of both the brain and the mind. Hoffman (1990) informs us that it is clinically important to recognize that all mental illness occurs in an ever-present, always evolving psychological and biological circle. Cabaniss (1998) talks about parallel models and how psychoanalytically-oriented psychotherapists are best served by adopting this combined approach: the psychoanalytic and the biological theories in tandem.

Gitlin (1990) says that there is no evidence that psychopharmacology and psychotherapy when used together are less effective than either treatment used alone. In

fact, combined treatment is found to be as effective or more effective than either treatment alone.

Effects of Combining Psychotherapy and Psychopharmacology

Positive Aspects of Combined Treatment

Psychopharmacology, when combined with psychotherapy, generally lessens symptoms which are driven by the central nervous system, making patients more capable of using their intellectual and verbal capacities. Both are necessary with a psychoanalytic approach (Bradley, 1990; Klerman, 1991; Miller & Keitner, 1996). Drug-induced symptom reduction lowers the patient's discomfort level and therefore facilitates his/her potential benefit from psychotherapy. Miller and Keitner (1996) and Bradley (1990) further state that psychotherapy can enhance compliance with a medication regime. Klerman (1991) continues on with this idea by stating that personal interest, education, and explanation all enhance a patient's positive attitude and cooperation, both toward the psychoanalytic process and toward the psychopharmacological process.

Helping patients to understand their illnesses in a biopsychosocial context is a relatively new idea and an exciting process. The idea that psychoanalytic therapy could be improved by the right amount of medicine given in the right way at the right time, is of great importance to the future of psychoanalytic psychotherapy and to patients who would benefit from both (Bluestone & Normand, 1985).

Negative Aspects of Combined Treatment

Many authors (Bradley, 1990; Karasu, 1993; Klerman, 1991; Miller & Keitner, 1996) suggest the possible negative effects of using medication in combination with psychotherapy or psychoanalytic work. The cure-all effect of medication is seen to encourage magical thinking on the part of the patient, which can decrease motivation for psychotherapy through promoting a passive, dependent reliance on the drugs or the psychopharmacologist.

Due to the fact that the patient's subjective level of stress is decreased because of the removal of symptoms, a disinclination towards insight-oriented psychotherapy can occur (Bradley, 1990). It is also believed that through the premature reduction in symptoms, there will be a premature undermining of defenses, which will result in symptom substitution (Karasu, 1993).

On the other hand, psychotherapy is at times seen as undermining psychopharmacology by its probing and identification of conflicts and defenses, which often increases anxiety and/or depression. From a psychoanalytic perspective, psychotherapy is seen as undoing the benefits of pharmacotherapy (Klerman, 1991).

The Therapeutic Triangle

Introducing a third person, the psychopharmacologist, into the ongoing treatment relationship has profound effects that must be understood and analyzed. While medication can facilitate the psychotherapeutic process, attention needs to paid to the development of the therapeutic triangle and all of its various ramifications, such as transference, countertransference, splitting, resistance, compliance, and collaboration.

The psychotherapeutic relationship utilizes brain-based processes of the participants to help patients (and therapists) improve opportunities for benefits from interpersonal relationships (Beitman, 1994). If we support the notion that social relationships are crucial to human functioning, then therapists are clearly serving biological needs that help stabilize and improve human functioning (Beitman, 1996). The analytic relationship is both interpretive and noninterpretive, but it is the therapeutic vehicle through which change takes place (Sandberg, 1998). Greenhill et al. (1983), Karasu (1982), Klein et al. (1983), Ostow (1993), and others talk about the "analytic attitude and the interpersonal connection" within the therapeutic triangle and within the therapeutic dyad as being most crucial to the relationship and the referral.

The therapeutic relationship is the umbrella under which issues and complications of transference, countertransference, medication compliance, resistance, splitting, and professional collaboration exist when a psychopharmacologist is introduced into an ongoing psychoanalytic psychotherapy. Finkel (1998) says, "There is now a literature on the benefits of combined approaches to treatment" (Greenhill et al., 1983; Karasu, 1982; Klein et al., 1983; Ostow, 1983). "I agree with the author's notion that psychoanalytic therapy can be improved by the right amount of medicine given in the right way at the right time. The most significant problem remains the effect on the analytic attitude and the interpersonal configuration of the treatment relationship" (Ostow, 1983, p. 237).

The movement from a dyadic to a triadic treatment relationship can potentially activate unresolved family issues (mother-father-child) (Bradley, 1990; Carli, 1999). For example, issues of rivalry, fear, anxiety, idealization, splitting, and devaluation could possibly come for all of these parties. To prevent or reduce the possibility that these

issues could interfere with the treatment process, both clinicians must understand the power of interpersonal dynamics, especially as they relate to triadic relationships. They must also resolve conflicts that occur between themselves that relate to the treatment of the patient.

In a triangular therapeutic arrangement a patient has two ongoing therapists: a psychotherapist and a psychopharmacologist (Kahn, 1993). The Group for the Advancement of Psychiatry (1975) asserted "the combination of therapy and medication reflects the clinicians' belief that neither treatment alone is enough, and that the combination will yield greater benefit" (Carli, 1999, p.182). Kahn believes that success in this triadic relationship depends on the patient and the pair of doctors who are forming this new three-way alliance. He suggests that they must all share a common view of the illness and treatment plan. A triadic therapeutic alliance requires, along with the right personal "match" (Luborsky & Auerbach 1985), respect between the therapists for each other's styles and thinking, and a communication of this mutuality of goals and ideas to the patient. Beitman et al. (1984) also discusses the psychotherapy-psychopharmacotherapy triangle and supports Kahn's idea that difficulties arise mostly from the psychotherapist and the psychopharmacologist holding different views about the diagnosis and its treatment.

In order for this new triadic relationship to work effectively, both professionals must have at least a beginning understanding and respect for the other professional's work. Busch (1998) emphasizes that from the initial consultation, medication becomes another presence in the room. When the decision to medicate is made and sometimes even when it's not, medication and its effects on the therapeutic relationship remain,

leaving a lasting impact that needs to be dealt with and understood in an open and analytic way. This emphasizes the importance that the psychotherapist have a basic understanding of the medications, their side effects, and potential actions in order to support this part of the treatment. Conversely, the psychopharmacologist must have a rudimentary understanding of psychodynamics to guide their own psychotherapeutic interventions, as the patient-physician relationship will be impacted by the patient's personality, and, therefore, this will affect the patient's response to the medication (Bradley, 1990).

Interdisciplinary collaboration may be awkward and a potentially conflictual relationship (Busch & Gould, 1993). Therapists' negative countertransference and interdisciplinary competition can undermine the case (Busch & Gould, 1998). The use of differing models to assess the patient's psychopathology, as well as proprietary attitudes toward the patient, can also become extremely problematic, thus emphasizing the importance of collaboration between the two professionals involved.

Brenner (1992) has cautioned those interested in the combination of medication and psychoanalytic work to avoid generalizations. Currently, we can assume that the medication will in some way affect the patient's thoughts and feelings about the primary therapist. Just what those reactions are will be different for every patient. Attention to the specific analytic material itself will provide these answers for each individual patient.

The Therapeutic Relationship

Medications are seen as alleviating symptoms, while psychotherapy is seen as improving interpersonal relationships and deepening self-awareness. Symptom reduction

or alleviation influences the patient-therapist relationship, and discussion of this relationship will affect the patient's symptomatic experience (Goldhamer, 1993).

Because of the unique nature of the interpersonal relationship between therapist and patient and its centrality for cure, Karasu (1993) suggests that the patient see someone else for medication consultation, and that the possibility of taking pills to alter the way in which the patient thinks or feels has a profound meaning to both the patient and the therapist. These meanings are rooted in each individual's sensitivities, past experiences, and transference/countertransference distortions. In order to integrate the consultation procedure into the psychotherapy and keep the psychoanalytic relationship intact, therapists must be prepared to explore their patient's reactions and their own reactions in an open and respectful manner (Gitlin, 1990). Drescher (1993) talks about the need for the therapist to be willing to explore all of the patient's arguments against the referral in an open and non-judgmental way. This would of course mean exploring the meaning of the referral to the patient as well as the meaning of taking the medication. This would mean the impact of introducing a third person in the patient-therapist relationship would need exploration.

Transference Reactions

Sandberg (1998) says, "The introduction of medication does not preclude understanding phenomena in terms of the inner world. However, it does preclude assuming a simple relationship between the psychological and the biological" (p. 634). Interpersonal patterns play themselves out between the therapist, the patient, and the psychopharmacologist around the use of medication. All three people in this "therapeutic

triangle" are potential contributors to medication-associated transference and countertransference distortions.

For all parties involved, the meaning of medication as opposed to its efficacy is legitimate grist for psychotherapeutic understanding and interpretation (Nevins, 1990). The actual referral and recommendation for consultation typically has multiple levels of meaning for the patient, as well as for the psychotherapist and the psychopharmacologist.

Busch and Gould (1993, 1998), Karasu (1982), and others write about the impact on the relationship when you introduce a psychopharmacologist. They highlight many of the transference and countertransference phenomena that occur in this situation.

The patient may experience the medication recommendation, referral, or actual initiation of drugs with a range of feelings such as relief, panic, anger, depression (Gould & Busch, 1998). Most authors (Bradley, 1990; Busch & Gould, 1993, 1998; Gitlin, 1990; Hyland, 1991; Knowlton, 1997; Riba & Balon, 1999; Schachter, 1993; Schuman, 1992) talk about the patient's various transference reactions. Some patients experience it as a rejection, meaning that their therapist no longer wants to work with them. Some feel that their problems are too overwhelming or that they are too "crazy." Another common response is to feel narcissistically wounded—they have let down their therapist; they are not good enough or have not worked hard enough.

The idea of "the parental couple" is seen in the Kleinian and contemporary Kleinian literature. Hanna Segal (1964) first speaks of this when speaking about the child's object relations and the experience of splitting, introjection, and projection. She says when the "parental couple" is introjected, it becomes an important part of the structure of the child's internal world. Ronald Britton (1997), in a more recent article

published in The Contemporary Kleinians of London, writes that the acknowledgement by the child of the parents' relationship unites his psychic world, allowing for the development and existence of healthy object relationships. He goes on to elaborate that when this development takes place, the child is able to live with and develop a belief in a secure and stable world. This theoretical stance dovetails with the thinking expressed by many of the contemporary writers (Bradley, 1990; Busch & Gould, 1998; Gitlin, 1990; Riba & Balon, 1999; Schachter, 1993) on transference issues to be considered when forming a therapeutic triangle.

Bradley (1990), Busch and Gould (1993, 1998), and Schuman (1992) talk about the various transference and countertransference reactions therapists have to a medication referral. Some therapists fear losing their patient; some fear being shamed by exposing their work; some feel competitive with the medicating physician. Encouraging the therapist, as was done in this study, to talk openly and directly about their unique experience, is a way of confirming or negating many of the ideas in the literature, while at the same time creating new ones.

On the positive end of the transference spectrum, some patients feel nurtured and understood by the introduction of a third person into the treatment relationship. The often-quick symptom reduction can create a feeling of magic surrounding the psychopharmacologist with a devaluing of the primary therapist. Anger is often a factor: "Why did you wait so long?" "Why did you let me suffer?" Some patients experience the triadic relationship with a sense of safety, a kind of "special child" status.

A split transference is a common side effect of triangular treatment relationships with the maternal therapist and the paternal psychopharmacologist (Gitlin, 1990).

Splitting typically takes the form of the good guy-bad guy split, where one person is seen as all good and the other as all negative. Who is good and who is bad can change from moment to moment (Goldsmith et al., 1999). These distortions are generally perceived according to the patient's childhood experiences and memories. The status of the transference at the time of the medication referral is very important. The longer a patient has been in one type of therapy, the greater the potential for the development of complications when a second clinician enters the picture (Chiles et al., 1991). This transference configuration is enhanced by our cultural attitudes as well as by developmental issues. Reactions to the psychopharmacologist in particular are made up of societal views towards physicians as well as transference distortions.

Ostow (1960, 1993) believes that if the transference to the therapist is positive, the patient will report a positive response to the medication and minimize its side effects. He states further that when the transference is negative, the patient will minimize the effect of the drug and complain about its side effects. Ostow additionally believes that prescription medication alters the transference and other aspects of the psychoanalytic relationship permanently and significantly. He finds that specific transference responses which entail feeding, poisoning, manipulation, and impregnation fantasies are common.

The introduction of a second therapist into a treatment relationship can be used by the patient as an ideal opportunity for splitting as a defense against looking at early internal conflicts (Bradley, 1990). With the introduction of the triadic structure, what has to be addressed are the patient's unconscious projections, identifications, and distortions as they relate to concrete, reality-based differences between the two clinicians, as well as to how they play out historically as reenactments.

Certain personality types are prone to view medication recommendations and referrals in specific ways. They are also more inclined to have clearly definable transference reactions. Ward (1991) has outlined a few of these reactions according to personality types and diagnosis. He says that with narcissistic patients, their need to be "special" must be attended to. Doing this will increase the patient's compliance and enhance their investment in the triangular relationship. Once this has been established, transference interpretations can therapeutically challenge the narcissism through analytic work.

He continues that with obsessive-compulsive patients, it is important to remember that those afflicted with this disorder are typically afraid of change. Descriptions of improvement need to be downplayed, as anticipation of change can decrease compliance or medication refusal. Borderline patients have as a core issue the fear of abandonment. Improvement, through the introduction of medication, might trigger the fear that they would be left. Some borderline patients feel reassured by the introduction of a second clinician into the mix, as they feel cared for by a parental couple. In this context they may feel heard, understood, and believed, yet emphatic statements about how well they are doing might frighten them, as this would signal abandonment.

Hostile dependent patients require special care. These patients often ask for extensive advice and complain a lot about all of those who have previously treated them. They seem to be more interested in defeating the process and the clinicians than in getting better. It is important to take a skeptical and low key approach with these individuals, at no point giving them the impression that you have any investment in their

getting well. Transference interpretations could come only after the medication had stabilized the symptoms allowing a capacity for insight.

Countertransference Reactions

Bradley (1990), Busch and Gould (1993, 1998), Goldhamer (1993), Hyland (1991), and Normand and Bluestone (1985) talk about similar and crucial countertransferential issues that the therapist must confront, so as not to interfere with the medication referral and possible drug implementation. All of the clinicians talk about how unacknowledged countertransference anxieties of the primary therapist can impede effective collaboration between two practitioners.

Some therapists may doubt their clinical abilities or may unconsciously need to avoid emotional connection or interaction themselves. One issue that can exist is that the therapist may feel shame about sharing his/her work or shame about requiring help. There may be a fear of being criticized. The treatment itself may have hit an impasse, and the referral is therefore a countertransference enactment in that consultation/ supervision and not medication is indicated. Roose and Stern (1995) talk about how in an ongoing analytic treatment, when a referral for medication is made, a central concern is the meaning of "turning the treatment over" to the medication or the psychopharmacologist.

A common countertransference issue on the part of the psychopharmacologist is that they collude with the patient's negative transference toward the primary therapist. Clinicians easily experience competitive feelings towards one another, which can give the patient fertile ground to unconsciously exploit this competition and consequently

undermine the treatment (Kelly, 1992). The psychopharmacologist, who is by definition a psychiatrist, can assert authority over the referring therapist, who is generally non-medical, and cause the patient to unconsciously collude and pull away from the primary therapist when this happens. The most important variable seems to be that some psychopharmacologists believe that medication renders psychotherapy unnecessary (Busch & Gould, 1998). One additional complication can come from the psychopharmacologist's resentment and/or his/her anxiety over having to share control of a case. Karasu (1993) makes reference to fears that most clinicians carried in the early years of analytic work, specifically during the '50s and '60s, that medication and the introduction of a third person into the dyad would interfere with the vicissitudes of the therapeutic transference or reduce patient motivation. Although these fears remain unfounded, they still linger in the analytic community.

According to Hyland (1991), the way the psychotherapist views the medication consultation is critical for the patient and for the psychotherapy. Patients take their cues from their therapists either consciously or unconsciously. Discussing feelings around a medication referral is just as important as discussing any other feelings in the psychoanalytic process, and usually offers a chance to increase the depth of the therapeutic process.

Collaboration Between Two Practitioners

Klerman (1991) reminds us that "often success in treatment involves the "goodness of fit" between the expectations and attitudes of patients and of the mental health professionals" (p. 18). Chiles et al. (1991) talk about each therapist's need to

know the other's impression of how the patient is doing and the general treatment plan. According to Jamison (1991), Busch and Gould (1998), and Finkel (1998), the collaborative nature of the patient-clinician relationship is central to effective treatment. Jamison goes on to say that when the two professionals create an emotionally supportive atmosphere, patients are more likely to express their concerns, and the professionals are then better able to assess the patients' needs.

Kelly (1992) reiterates the idea that common sense dictates that two clinicians would confer frequently and share impressions about a patient in common. However, he cautions that an overly close collaboration can be destructive to the treatment. He emphasizes teamwork and uses an analogy of how in a healthy home each parent conveys respect for the other and for the child, but that does not necessarily mean that their personalities are identical, nor are their functions or their views. Roose, in a 1997 Internet interview in Psychiatric Times with Knowlton says, "If combined treatment is faring poorly, then raising the dose or interpreting the transference may not be the key intervention. Rather, it may be attention to the relationship between therapist and consultant that will correct the course of what is very often effective treatment" (p. 4).

Finally, Goldsmith, Paris, and Riba (1999) talk about the psychotherapist's role as helping the patient to introspect and deal with the anxiety and depression producing aspects of his/her life. It is the psychopharmacologist's role to prescribe the medication, and the patient must more or less passively comply if the treatment is to work. They emphasize how these mind/body roles represent the dualism in our culture and express contrasting ways to solve a problem. The view that one is right and the other wrong is considered to be the prime pitfall of medication collaboration, in their opinion.

Conclusion

In spite of the fact that actual research about the effect on the relationship that introducing a psychopharmacologist into an ongoing psychoanalytic psychotherapy is scant, the articles and books reviewed in this chapter provide a solid basis for clinical thinking related to this idea. The material reviewed, as well as the researcher's own experience, indicated that this subject deserved further qualitative study. The information from this study can then be used to further enhance and understand the complicated interaction that exists between the three members of the "therapeutic triangle": the patient, psychotherapist, and psychopharmacologist.

Neurobiology continues to influence the psychoanalytic process (Cooper, 1985). Psychoanalytic work is the indispensable tool for understanding the inner world and the complexities of human experience. Psychopharmacology is the clinical application that balances one's psychobiology. Psychopharmacologists, psychotherapists, and patients are beginning to realize that effective medication treatment and consultation can do more than simply treat an illness. It can truly transform the person.

Assuming that the therapist thoroughly explores and interprets issues related to a patient's biological illness, the psychotherapeutic or psychoanalytic process should not be interfered with by the introduction of a psychopharmacologist, but rather it should be facilitated (Kantor, 1993), as it was in the six cases discussed in this study.

CHAPTER III

METHODOLOGY AND PROCEDURES

This chapter will discuss the methods and procedures that were used in this study. First, there will be a discussion of the research design, specifically as it relates to issues of qualitative research. Following this will be a description of the pre-interview questionnaire and the selection of subjects. The chapter will conclude with the details of data collection, as well as the interview guide, and a description of the data analysis methods.

Design of the Study

Patton (1990) describes two distinct method choices when approaching research. He says, "Qualitative methods permit the evaluator to study selected issues in depth and detail. Quantitative methods, on the other hand, require the use of standardized measures so that the varying perspectives and experiences of people can fit into a limited number of predetermined response categories to which numbers are assigned" (pp. 13-14).

Exploring and clarifying data in areas where knowledge is lacking, is one goal of qualitative research. Qualitative research also is very useful for describing processes at a fine level of detail and can be very useful for exploring situations that emphasize individualized outcomes, such as patient or therapist responses to specific phenomena. The fact that much of the audience for this study would likely be psychoanalytically oriented therapists, much of whose knowledge base is enhanced from case studies, provided an additional rationale for the use of qualitative research.

This study drew extensively on the grounded theory method, which was one of the types of qualitative research available and which has been outlined by Strauss and Corbin (1990). Grounded theory is best applied to the social and psychological sciences in that they are not considered "hard sciences," and they are constantly dealing with evolving variables of human emotions and subjective perceptions. This study looked at the therapist's perception of what happens to his/her relationship with a patient who is in ongoing psychoanalytic psychotherapy when a psychopharmacologist is introduced to prescribe medication. It first looked at how the therapist thought about the interplay of the psychological and biological aspects of the patient's difficulties. Second, it looked at the therapist's perception of the impact that the introduction of the psychopharmacologist had on the therapeutic process, especially the transference and countertransference. Thirdly, the study looked at how the therapist changed the therapy once the psychopharmacologist had been introduced into the treatment situation.

Beginning with her own clinical experience and knowledge gained from the literature, the researcher conducted semi-structured interviews (see Interview Guide), which looked at such things as indications the therapist uses for considering a referral to a psychopharmacologist, how the relationship was impacted by the introduction of the psychopharmacologist, and how the therapist intervened or handled the therapeutic process as a result of the perceived changes.

Procedures for the Selection of Subjects

Participants for this study were contacted through the 1999 Committee on Psychoanalysis in Clinical Social Work Membership Directory for the Southern

California area via a personal introductory letter (see Appendix A). This list was selected because all of the members are senior (at least five years post masters) clinicians with social work backgrounds. Therapists were selected from those who have been primarily in private practice with a psychoanalytic frame of reference and who saw patients in intensive (2-4 times per week) long term treatment. Participants who were selected also had psychoanalytic psychotherapy or psychoanalysis themselves and had some post masters training and/or supervision. The respondents to the initial request who had the most experience with psychotropic referral and the most clinical experience with long term psychoanalytically oriented psychotherapy were the ones finally selected. Social work respondents were selected with the hope that this choice would strengthen the study's relevance to the field of social work in particular. Since the researcher had been in this social work community for many years and had served on the Board of the Committee for Psychoanalysis in Social Work, she knew most of the respondents as professional colleagues.

There was an introductory letter and pre-interview questionnaire (see Appendix B). The prospective participants were asked to fill it out if they were interested in participating, and they were also asked to return this questionnaire within two weeks in a self-addressed, stamped envelope, which was provided. A copy of the Informed Consent (see Appendix D) was included for the prospective participant to review before final consent was obtained at the time of the interview.

The sample size was intended to consist of eight participants. The researcher felt this number was large enough to allow room for dropout, yet small enough to still allow for in-depth description. Ten participants were actually selected and interviewed, but due

to some technical difficulties with the recording equipment, four of the interviews were not useful for much of the data analysis. While the researcher was able to analyze the data from only the last six interviews, she was able to use the experience and information gained from the first four interviews to inform and direct the following interviews.

Data Collection

Data was collected from the participants by using face-to-face, semi-structured interviews that were audio taped. The interviews were scheduled for one to two hours in duration and took place in a setting that provided confidentiality, no distractions, and convenience for the participant. Each participant was asked to discuss in detail one case in which they had made a medication referral.

An open-ended interview style was used in the hope of discovering new ideas, while at the same time giving each participant full range with which to respond, to express their insights, and to make connections in an unrestrained way.

Narrative descriptions were obtained from the participants about their perceptions of the interplay between psychological and biological aspects of their patients' difficulties. Also, respondents were asked to describe their perceptions of the impact that the introduction of the psychopharmacologist had on the therapeutic process, especially the transference and countertransference. A narrative description about the ways in which they changed their therapeutic style once the psychopharmacologist was introduced into the treatment situation was sought.

The researcher's role and the interview style were interactive. This allowed the researcher to both question and draw out the interviewee's responses and to more fully

illuminate their individual points of view. At the same time, the researcher attempted to avoid imposing her own ideas on the participants, but rather hoped to elicit each participant's perceptions about the changes in the relationship with their patients after a psychopharmacologist had been introduced into the psychoanalytic mix. Patton states, "Qualitative interviewing begins with the assumption that the perspective of others is meaningful, knowable, and able to be made explicit" (p. 278). This is in keeping with the social work notion that you start where the client is and you stay with the client, therefore, emphasizing the importance of the other's thoughts, feelings, and reactions.

Interview Guide

The Interview Guide (see Appendix C) was made up primarily of open-ended questions that were arranged around specific topic areas. The first set of questions inquired about indications that the therapist uses when considering a medication consultation with a psychopharmacologist, in particular what they thought about the interplay of the psychological and biological aspects of the patient's difficulties. Next, they were asked what their perceptions were of the impact of the introduction of the psychopharmacologist on the therapeutic process, especially the transference and the countertransference. Lastly, they were directed to talk about how they may have changed their therapeutic style once the psychopharmacologist was introduced into the treatment situation.

The researcher used the Interview Guide to assure that the same basic areas were covered in each interview; however, the order in which the areas were covered varied from one respondent to the next. This researcher used the participant's responses as a

starting point for the line of questions used to gain elaboration on a topic in any given interview situation. It was hoped that the open-ended Interview Guide would facilitate individual narratives, as well as allowing for variations in these narratives around the topic expressed.

The following were the topics used to guide the interview, discussion, and elaboration process:

I. What Indication Did the Therapist Use for Considering a Referral to a Psychopharmacologist for Medication?

This topic began with an exploration of the therapist's perception of what was happening in the relationship with the patient at the time when the therapist began thinking of making a referral for medication.

The participant was directed to pick a particular patient whom they had referred for medication. They were instructed to talk about and elaborate on their thoughts and feelings about why they thought a referral was indicated and how they differentiated or thought about what behavior in this patient caused them to think a medication referral was indicated. They were asked to talk about their thoughts and perceptions about when they first started thinking about a medication referral through to when this patient actually started on and began a medication regime.

II. How Was the Relationship Impacted by the Introduction of the Psychopharmacologist?

Here, the researcher wanted to explore the therapist's perceptions of how the relationship was impacted, with specific examples and vignettes coming directly and

spontaneously from the participants. The researcher was especially interested in the transference and countertransference that occurred in this situation.

III. How Did the Therapist Intervene or Handle the Therapeutic Process as a Result of the Perceived Changes?

What did the therapist observe going on between himself/herself and the patient once the psychopharmacologist had been introduced into the treatment situation?

Here, the participant was directed to think about a point in time when this patient was actually on medication. Then they were asked to expound on any changes they noted, particularly as they related to the transference and the countertransference, as well as the relationship as a whole.

Protection of Human Subjects

In an attempt to protect the confidentiality and privacy of the therapeutic relationship, participants were instructed to use fictitious patient names, and they were told that all materials from the interviews would be destroyed as soon as the research project was completed. All case material that was used in writing of this study's findings was disguised for purposes of confidentiality. All these steps were taken to ensure that this research did not violate the patient's or the therapist's rights to confidentiality. In fact, it was for concerns about patient confidentiality that the researcher made a decision not to interview patients directly and to use only the therapist's perceptions.

Data Analysis

It was this researcher's proposed goal to interview and audio tape eight therapists and then have these taped recordings transcribed by a professional transcriber, then coded by the researcher herself. Some of the methods in the creation of categories were borrowed from what Strauss and Corbin (1990) call the "constant comparative method," where each interview informs the next through the understanding of the previous interview.

Creswell (1994) describes a process where the researcher takes "a voluminous amount of information and reduces it to certain categories, or themes" (p. 154). This method was employed. In the data analysis, the data from each interview was compared across interviews. This allowed the researcher to explore the common patterns among all of the participants (Strauss & Corbin, 1990). The researcher read each transcript and then put each one on different colored paper. Next, each audio tape was listened to by itself and then listened to again while at the same time reading each transcript. Next, the researcher went through each transcript and underlined all of the sentences, phrases, and comments that seemed to be alike. The transcripts were then cut into pieces according to these phrases and put into piles based on similarity of content. The data from each interview was then compared. Conceptualization started with the topic areas outlined in the Interview Guide, but primarily was based on the meaning that emerged from the interviews themselves (Patton 1990). An analysis following qualitative procedures was done using the transcriptions of the interview sessions and the interviewer's written notes. Certain ideas kept coming up repeatedly, and these were formed into categories.

For every three or four categories a theme emerged that tied together the various categories.

CHAPTER IV

FINDINGS

This study explored "What Happens to the Relationship Between the Patient and the Therapist When a Psychopharmacologist is Introduced Into an Ongoing Psychoanalytically Oriented Psychotherapy."

After a brief review of the methodology and the data analysis procedures used and a discussion of the participants' demographic information, this chapter will be organized around a detailed discussion of the four themes: "Is anything happening here?" "parental couple," "therapists' inner process," and "working relationship," which emerged from the analysis of the participants' responses to the three questions asked. The chapter will end with a summary of the findings.

Review of the Methodology

As was previously stated (see Chapter III), this study used an exploratory, qualitative design. Beginning with the combined knowledge of her own clinical experience and the literature review as the basis for the research questions, the researcher conducted semi-structured interviews with ten experienced psychoanalytic psychotherapists. The psychotherapists were selected from the 1999 Committee on Psychoanalysis in Clinical Social Work Membership Directory for the Southern California Area.

Ten participants in all were selected (see Chapter III for details) and interviewed. However, due to some technical difficulties with the recording equipment, the first four

of the interviews were not successful. While the researcher was able to analyze the data from only the final six interviews, she was able to use the experience and information gained from the first four interviews to inform and direct the following interviews.

Once these interviews were completed and transcribed, the researcher read each transcript and then put each one on different colored paper. Next, each audio tape was listened to by itself and then listened to again while at the same time reading each transcript. Next, the researcher went through each transcript and underlined all of the sentences, phrases, and comments that seemed to be alike. The transcripts were then cut into pieces according to these phrases and put into piles based on similarity of content. The phrases from each interview were then compared. Certain ideas kept coming up repeatedly, and these were formed into categories. For every three or four categories a theme was identified that tied together the various categories by a kind of story about the ideas within each category.

Initially, three themes were identified. Then, while reviewing examples of responses that fit each category, the researcher decided that a fourth theme, the "working relationship," helped to explain the data. Next, all of the transcripts were re-read to pick up any missed examples, and once again themes and categories with examples refined.

In an attempt to break the data into categories and themes, the researcher used her own clinical experience to think about how the subjects' responses were similar to or different from what she had learned to expect based upon the literature review. She tried to put her pre-conceived ideas aside and to begin with the meanings that came from the interviewees themselves. The categories were therefore created out of repetitive

statements made by the participants, and the themes were names given to identify the groups of categories that best described a kind of story they told.

Demographic Information

All six participants were Caucasian females. Their ages ranged from 45 years of age to 75. All participants were graduate level social workers, four of whom had Ph.D.s in Clinical Social Work. Three of these participants additionally had Psy.D.s; one was currently in a Ph.D. program in Clinical Social Work; and one was in a Psy.D. program at the time of the interview. The two participants who had only master's degrees also had extensive post masters training and experience. The participants had anywhere from 14 to 45 years of clinical experience, and all were in full time private practice in Los Angeles and its surrounding areas.

All of the participants had received either long term psychoanalytic psychotherapy or psychoanalysis themselves. All of the participants were or had been in some form of consultation, and four had consultation for the patient they discussed. They all defined themselves as psychoanalytic psychotherapists and reported that they see most patients a minimum of twice per week. They all saw themselves as either having an Object Relations, Intersubjective, or Relational theoretical stance, and most saw themselves as using an integration of these theories.

In the interview, when participants were asked to focus on one patient in particular, all picked a patient that they had worked with long term, anywhere from three months to six years pre-referral and anywhere from 2 years to 12 years post-referral. All patients were seen at least twice per week, and some were seen as frequently as five times

per week. Two of the patients discussed were diagnosed with Anxiety Disorder, two with Depressive Disorder, one with Depressive Disorder with Phobic Features, and with one Bipolar Disorder.

Themes and Categories

This study about the impact a psychopharmacologist has on a therapeutic relationship produced four themes. Three were direct responses to the research questions, and the fourth developed out of the participants' discussion of the factors that made the collaboration either positive or negative. All of the themes with their specific categories, definitions, and examples follow.

The categories in all the themes are closely intertwined and overlapping as well as being separate. It was conceptually difficult for the researcher to define completely distinct and mutually exclusive categories. Therefore, in a number of cases the same participant response appears in more than one category.

Theme 1: Is Anything Happening Here?

The answers to the first question, "What indications did the therapist use for considering a referral to a psychopharmacologist for medication?" were grouped into four categories. Either the patient was experiencing intractable depression, impenetrable anxiety, needed an emotional floor, or was feeling stuck. The common theme in these categories is the question of "Is anything happening here?"

When engaged in psychoanalytic psychotherapy, the psychotherapists in this study primarily use the relationship between the patient and the therapist, not

psychotropic medication, to effect internal change. Those interviewed in this study believe in deep analytic work and believe that intra-psychic change is possible through the work in the transference and countertransference. Traditionally, the psychoanalytic community, of which these participants are a part, has seen the use of medication as either resistance or as a therapeutic failure. Even though this thinking is changing (see Chapter II), these participants still prefer using only the relationship and not medication, unless medication is absolutely necessary, because the patient is unable to use the therapy without medication.

The theme of "Is anything happening here?" describes the therapists' feeling that nothing was happening in the therapy, that they were unable to really help their patient. They had a sense that there is a kind of invisible wall between them and their patient and that nothing can get through that wall, and if it does, the patient just cannot hold on to it. This led them to question themselves and their work with their patient and eventually to refer for medication.

The respondents had their own unique way of expressing/describing how they felt when they were thinking about a referral with the particular patient they discussed. For instance, one spoke about "realizing something just wasn't getting in," while another spoke of "a core of depression and anxiety that seemed immovable." Still another spoke about her patient's lack of movement as "worrying her." "I'd go home at night worried about her." This same patient was described as "having nothing to hold onto; it seems as if there's a black hole inside her."

Other respondents spoke of their patients' phobias that did not seem penetrated by the analytic work, of a feeling that nothing was getting in, and of a kind of "stuckness"

with symptoms generally being pervasive, immovable, and impenetrable through the use of interpretation and insight. To the researcher it seemed that all the participants expressed a sense of frustration and puzzlement at what was happening or not happening in the treatment with their patients. Sometimes this was prompted by the patient's complaints, but often it came from the therapist's own experience of the patient's dynamics.

Category 1: Intractable Depression

Four of the respondents spoke of their patients' "intractable depression." The therapist quoted below talks about her patient's anger that she thought was covering her patient's depression. This patient, in a previous therapy, had been on medication and had specifically come to this new therapist wanting to work things through without using medication, although it had previously been helpful with her depression. Here, as the therapist talks of nothing getting "in," she expresses that sense of "futility," that sense of a steel wall trapping in the old and keeping out the new.

> I realized something just wasn't getting in. She couldn't feel, she could intellectualize, but nothing ever seemed to get inside. She had real phobias that just wouldn't budge. I could just feel an intractability of her symptoms and a real stuckness in our work.

When the therapist says, "She could intellectualize but nothing seemed to get in," she is referring to the fact that the patient could talk as if things were changing but nothing ever changed. This same quote is repeated later in this chapter because it is also an example of "feeling stuck."

With regard to her patient's intractable depression, the next participant said that things were blocked in her patient and the "core of depression" felt "immovable."

> No matter how much we worked through, there was a core of depression and anxiety that seemed immovable.

The next respondent continues to describe this sense that the patient's symptoms were not moving:

> Finally, I realized after one phone call in particular, that this was intractable depression. He had anxiety and depression, and it seemed to be intractable.

Another participant describes the fixed sense she had of her patient's psychological state when she says, "She felt unmovable by any interpretation."

In the following quote, the researcher actually felt that sense of the oceans waves, hitting over and over on top of one another, constantly, when the therapist said:

> The despair was palpable. You could feel it. She was in utter and absolute despair and it was unremitting, and that's what provoked the referral.

One therapist describes her patient's experience of intractable depression in the following quote:

> There is a sense of the circular entrapment that is immobilizing. The patient's anger is clear, and the depression feels locked under the anger, phobias, and obsessions. She has patterns and numbers running around in her head all the time. She can't listen or take anything in. There's no room for feelings, sadness, mourning, and working through. Her phobias are never touched; even though her behavior in the outside world has changed, these remain the same. We keep getting to the same ideas over and over again and she keeps getting pissed, really angry with me over and over again how nothing has changed.

The lack of an ability to experience any joy or happiness, which is an integral part of depression, is expressed in the following quote:

> He didn't experience any happiness or joy in his life, and he wanted to find happiness and joy. He presented this as his only problem; he reported no other conflicts.

Category 2: Impenetrable Anxiety

"Impenetrable anxiety" in this study is characterized by excessive worry and difficulty controlling the worry so that it impinges on the individual's ability to function and/or think clearly. One of the interviewees spoke of "phobias that weren't getting impacted by the analytic work and causing anxiety." It seemed to the researcher that when the therapist spoke of the patient "not getting impacted by the work," a feeling of immovability was expressed. The researcher observed that this feeling seemed to cause further frustration for the therapist that was expressed as the patient's level of impenetrable anxiety. Another therapist spoke of the "repetition of the dynamics" in her patient as leading to a feeling or sense of impenetrability. Two of the respondents spoke directly of impenetrable anxiety as the main diagnostic category or symptom in their patients, while two others spoke of intractable depression as the main category with impenetrable anxiety being part of the depression. This is seen as one participant talked about how her patient was always anxious, about how nothing that they said or did seemed to affect how she felt. She said she finally recognized that

> I realized that my patient needed something to take the edge off of his anxiety.

The researcher understood this participant to mean that "this something" would allow him (the patient) to calm down enough to "take in" what she was talking about and allow more of the therapeutic work to move. This was corroborated by this respondent's additional discussion in the interview about the differences in her patient's ability to take things in emotionally once he had been on medication for a while. This same therapist, earlier in the interview when describing this patient's treatment history, goes on to show how this man's anxiety interfered with his ability to process reality and/or think clearly.

> During the first year, our work dealt with his constant sense of anxiety, his paranoid fears, his difficulty in a relationship with an ex-wife in terms of sharing their daughter with whom he did have custody but had to share some of that with his ex-wife. He was extremely anxious and paranoid about the ex-wife's behavior. He would have periods of extreme panic attacks, and I would get frequent phone calls from him that year.

The next interviewee shows how the patient's anxiety prevents him from holding onto or taking in the therapist as a real object with any consistency. She said

> He would seem to get to things, be in sync with me and the work, and then something (generally minor) would occur and he would decompensate, become extremely agitated, anxious, and panicked. The repetitive nature of this dynamic began to make me feel his anxiety was impenetrable, you know, maybe biological.

Category 3: Patient Needing an Emotional Floor

The third major reason that therapists referred their patients for medication was the realization that their patients "lacked an emotional floor" and did "not seem to have anything to hold onto." A lack of an emotional floor is described by one therapist as looking like "an elevator that doesn't stop at the first floor but rather keeps on going past the basement." This same therapist spoke about how her patient's emotional states appeared to have no "bottom," to be "uncontained." Still another participant described her patient as being "like a sieve that things constantly run through." This researcher understands the lack of an "emotional floor" as meaning that the patient appears to have no end point to emotional experiences. The emotional experiences seem to go on forever and ever with a never ending downhill kind of spiral motion. The lack of an emotional floor, like intractable depression and impenetrable anxiety, prevent the therapy from being effective and lead to a referral for medication.

The examples that follow exemplify the ways in which five out of the six therapists interviewed felt that some additional containment in the form of medication was necessary in order for their patients to do the internal work that would allow them to live more comfortable lives.

The therapist who described her patient as being "like a sieve," who couldn't really integrate or hold onto things, said

> I realized something just wasn't penetrating, or if it was, it seemed to just run right through her.

The next respondent talks more to her patient's edginess and anxiety as being the reason she seems uneven. She had implied earlier in the interview that her patient's anxiety had a "never ending," always intruding quality, which often prevented any forward movement in the analytic process.

> I had this feeling, and I realized that after all of our work, she needed something to give her a floor, to also take the edge off her anxiety.

The next example shows how the patient's anxiety prevented him from experiencing much of anything or taking much in. It was this therapist's experience that the patient's anxiety was constantly in the forefront, never allowing him to deal with any other material. This "never ending" quality of the emotional state referred to by the description of "being inside a washing machine always on the spin cycle" exemplifies the "lack of an emotional floor."

> He was so flat yet so agitated all of the time, he always wanted me to fix him. To make him feel happiness, that was all he wanted to feel, yet all he could feel was his own internal discomfort that he described like being inside a washing machine always on the spin cycle. He was totally unable to experience anything that was going on in our work together.

The final example in this category shows the "never ending" cycle and unpredictable and chaotic nature of a patient who has "no emotional floor." This therapist said her patient had this "never ending cycle," which she would call his "crash and burn pattern."

> He had this crash and burn pattern. He wouldn't eat, he wouldn't sleep, and he would wonder why he would end up feeling suicidal. His abject self-neglect was amazing; he had no interest or no ability to think of himself at all.

Category 4: Feeling Stuck

In the last category, "feeling stuck," therapists spoke about feeling patients could "intellectualize but not feel," that they would not see any notable change after "three years of work," or they would say things like, "After years of work, he still needed to call frequently." Stuckness, therefore, looked to the researcher to be a kind of subtext and, therefore, a category of the larger theme, "Is anything going on here?"

Even though "stuck" can be seen in all of the other themes, it needs more emphasis, as this appears to be the main idea these therapists report feeling when thinking about making a medication referral. Participants expressed their own questioning about whether or not any actual work was taking place. The respondents also reported that their patients complained of "feeling stuck." "Feeling stuck" is defined as those points in the treatment when either the patient or the therapist or both feel nothing is moving or changing despite whatever reality factors may exist to counter this feeling.

The researcher found one of the most profound expressions of "stuckness" to be stated below where the therapist's expression is not only one of "intractability" and impenetrability" but of "nothing moving" and of "needing help" as well.

> What I noticed was that even though change took place, he continued to have a kind of severe anxiety along with some depression. No matter how many insights he got or what happened in our work, no matter how trusting he felt of me, his depression and anxiety persisted. Nothing moved it, and I finally felt that we both needed help and wondered if medication might not help.

This example, along with those that follow, exemplify the therapists' feelings at the point at which they decided a medication consultation might be beneficial for them or for their patient.

The following respondent directly talks about impenetrability and intractability, as well as stuckness, when she says

> I realized something just wasn't getting in. She couldn't feel, she could intellectualize, but nothing ever seemed to get inside. She had real phobias that just wouldn't budge. I could just feel an intractability of her symptoms and a stuckness.

The following statement clearly illustrates not only the patient's difficulties, but also the therapist's feelings. This researcher could feel the therapist's sense of futility as she listened to this description of stuckness, intractable depression, and the therapist's sense of confusion.

> After working with him for three years, there was no notable change in his affect, his way of being able to relate to me. He was still unable to even focus on me at all. He was experiencing difficulties at home with his wife; he was having trouble getting up in the morning; he was feeling despairing; he was feeling lethargic; he was sleeping in session with me and sleeping a lot generally. It felt to me like he was lost. I felt lost myself and confused.

The next example, although cutting across many categories, is being used here to demonstrate "stuckness." This is seen when this respondent says, "It seemed that there was a black hole inside of her." The researcher heard and understood this to mean both a

floor was absent and that "movement" was absent as well (see categories of "feeling stuck" and "needing an emotional floor" for additional clarification).

> The despair was palpable. You could feel it. There was nothing for her to hold onto. When I think about referring for medication, I think about establishing some floor in the feeling level of the patient, and with her it seemed that there was a black hole inside of her.

Theme 2: Parental Couple

The answers to the second question, "How was the relationship impacted by the introduction of the psychopharmacologist," was grouped to the following categories: emotional repair, psychological re-enactment, and splitting. The common theme in these three categories is "parental couple."

When the participants were asked how they thought the introduction of the psychopharmacologist impacted their relationship with the patient, their answers did not focus on transference and countertransference or the therapeutic relationship per se. Instead, their answers focused on the formation of the new triangular relationship between the therapist, the patient, and the psychopharmacologist and the opportunities for growth that this new relationship would provide if effectively managed. The researcher called this new relationship the "parental couple," because it allows the patient to transfer and/or rework old parental feelings through the use of the relationship with both the psychopharmacologist and the primary therapist. The participants talked about three ways in which their patients used the "parental couple" in order to rework past problems: repair, re-enactment, and splitting.

Category 1: Repair

"Repair" is defined as those times when the patient experiences the new triangular relationship in a way that helps to heal earlier wounds, particularly as they relate to their early family history. It must be remembered, however, that this description is the respondent's/therapist's understanding and expression of the patient's experience. Four therapists reported the patient's experience of the relationship with the psychopharmacologist combined with the relationship with the primary therapist as feeling like a repair of their earlier, often more dysfunctional, parental experience. Of these four therapists, all spoke of the positive change they observed in their patients due to this experience. These respondents referred to the idea that this new triangular relationship allowed for "repair" of their earlier, often dysfunctional, relationships. Throughout the interview, and not just in response to the second interview question, the researcher feels this category is best captured by one of the therapists when she says, "He really badly wanted to think of us as working together...that he could depend on both of us, that there wasn't a split between us." Another therapist talks about repair when she says, "She liked to flirt with him; she was almost little girlish with him. At other times she would rebel; she liked seeing him." As this therapist went on to explain more about this patient's history, she explained that the patient's mother was "supportive but inadequate," and her father was a "mean, controlling son-of-a-bitch." This then meant that this patient's experience with the psychopharmacologist combined with her relationship with her primary therapist, offered a new experience, a "parental couple" that contained "repair" of the original parental experience.

The first vignette shows how the patient was actually able to re-work old experiences. The statement quoted below is one that this participant formulated towards the end of the interview when she was thinking about the over-all impact that she felt the introduction of the psychopharmacologist had had on her patient. When this participant recounts the patient's feelings of having now both a "man parent as well as a female parent," the scope and possibilities of "repair" is felt.

> She (the patient) would have healthy fights with him (the psychopharmacologist) about money, following directions, etc., and I wouldn't intervene, and she felt she could finally stand up to "daddy." She talked about how she now felt that she had a man parent as well as a female parent who could talk about her with real attention without being afraid that the other would be disturbed.

Another example of repair is seen when this therapist reflects on how a compliment from the male psychopharmacologist is "more validating," that is, more reparative than a compliment from her. This is true because the patient's experiences with her father and of men in general were demeaning, verbally and sometimes physically abusive. This was an instance where a male, and one of high status, a physician, saw her with high regard, thus allowing her to repair some of her earlier experiences with men.

> I think his seeing and validating his experience of her intelligence to her, you know, "you're really smart," when he thinks he's the smartest person in the world, I think. I don't know, but he thought she was brilliant and I, of course, you know, I told her that and that has given her confidence, but honestly, not that she doesn't think I'm smart, but because he's male, it's been more validating.

This next therapist was describing her patient's very disturbed past, remembering how both absent and controlling the patient's parents had been. The sense of "repair" is illustrated when the therapist says

> He came to see the psychopharmacologist as a caring father and me as the effective mother he'd never had, who was willing to run interference for him and make things clearer to "daddy." He had never felt so calm and not anxious before and didn't know this was possible.

Reflecting on the repair brought about for this patient due to the introduction of the psychopharmacologist, the therapist stated

> The psychopharmacologist became the effectual father; I became the mother that he could trust. He was able to do some reparation from his past in relation to the father and the mother.

The following respondent reported the repair experience for her patient in a very concrete way. The patient was very young, and the therapist spoke at some length about the new parental experience, truly allowing this young woman to turn her life around. She said

> For her the introduction of the psychopharmacologist, perhaps because of her youth, created a familial environment and it felt like, on the one hand, she had two healthy, well-functioning parents on whom she could lean, not feel like she burdened them, which was so unlike her own parents that it supplied her with a kind of alternative family. She saw me as an effective mother and the psychopharmacologist as a father she could stand up to and not feel helpless, as she had with her biological father.

Another therapist, when asked to summarize her thoughts about the nature or way in which her relationship with the patient shifted with the introduction of the psychopharmacologist, spoke about the parental repair created by the psychopharmacologist when she said

> Well, I think what happened is that the patient, having had this psychotic mother, always looked to his father to rescue him, and the father never did, and I believe that his experience of the psychopharmacologist was the rescue by the father.

She went on to speak later about ways in which she was the "good mother and/or grandmother." This patient apparently ended his treatment approximately one year after

this consultation only to continue with this "male" psychopharmacologist for both therapy and medication. According to the therapist, both professionals felt this was a "good, solid, reparative" experience for this patient.

Category 2: Re-enactment

This category is defined by those times and/or experiences when the patient perceives either the psychopharmacologist or the primary therapist through a historical (transferential) lens, reflecting some aspect of their own early experience rather than being able to perceive the person for whom they are, more in keeping with today's realities. Re-enactment is an unmodified replaying of an old pattern as distinguished from repair, where the new relationships modify the old, dysfunctional pattern.

While four of the therapists specifically spoke about and gave examples of re-enactment, it is sometimes hard to completely distinguish re-enactment from repair and splitting. Many of the therapists gave examples that fell into all three of the categories, which highlights the overlapping nature of the categories.

This is best exemplified in the following respondent's statement, "Her reaction (to the psychopharmacologist) had a lot to do with her history." Here the therapist is referring to her belief and understanding that her patient is belittling the psychopharmacologist and seeing him as "odd" in an attempt to feel some power over a dominating/controlling father. This therapist goes on to say, "She was critical of him, sort of ridiculing of him, and I'm not sure what it was in the service of." This example again highlights the category of re-enactment. First, the therapist used her own questioning of the statement, "I'm not sure what it was in the service of" as a stepping

stone to further exploration of the nature the patient's relationship with her father and, therefore, the historical nature of the re-enactment with the psychopharmacologist.

The following respondent describes her patient's fear that a re-enactment would occur. She reports that her patient is afraid that the psychopharmacologist will become her "over-powering father."

> She was always afraid of losing control of herself, of my losing control to the more 'powerful male physician' who represented her father and her experience of losing control and being helpless when she was a child.

The next participant states her patient's re-enactment and her understanding/ interpretation that he was seeing her and the psychopharmacologist through a distorted lens, as if they were actually his mother and father of childhood.

> He thought the psychopharmacologist was very odd, that his office was odd, that he was very disorganized, which he isn't, and what a strange thing for me to be sending him to someone who's so odd. We ultimately understood his disappointment as relating to his father and mother, not really to me.

Next, she goes on to describe examples of his re-enactment fears and her interpretation and understanding of his reactions by saying she felt "this was a feeling experience from his childhood."

> The minute he had to go to see someone other than me, he became extremely frightened and very mistrustful and angry with me. Again, this was a feeling experience from his childhood.

His earliest wishes and fantasies for a "good mommy," and his disappointment that his therapist was not this fantasized mother but rather a repeat of the earlier disappointing mother, the biological one, is implied when this respondent said

> He wanted to know, why don't I have a magic wand and why can't I just fix him myself. We ultimately understood this as his earliest wish to have had a mother who was warm, attuned, and could have helped him to feel safe.

This is seen again when the next therapist gives an example of re-enactment at a deeper psychological level, one that she assumes theoretically existed for the patient during his infancy. She illustrates his fantasy clearly below and goes on further to describe the patient's disappointment at feeling this "mommy" was "bad" like his first mommy. Here, the experience of re-enactment is seen through the therapist's perception and theoretical understanding of her patient's internal feelings and fantasies rather than through the patient's verbal or physical actions.

> He felt betrayed by me that I was giving up on him, that I promised that we could do this together, just us, and now I was involving an outsider. He had a deep and abiding investment in my having total and magical control over the therapy and his capacity to get better; he wanted us to be the perfect "mommy-baby" pair who needed no one else in our lives. His fantasy was so intense it actually had delusional qualities to it.

Another example in this category is also based on the participant's theoretical position, which presumes early infantile wishes are repeated in many adult situations. She interprets that the patient felt "excluded by the mother and the father" when she says

> It set up the parent-child situation with the child [her adult patient] feeling excluded by mother and the father as he had as a child. He felt left out because I had a relationship with the psychopharmacologist and he didn't feel included, like when his mother and father closed the bedroom door.

Still another therapist recounts an important situation where a failed referral to a psychopharmacologist re-enacted the patient's experience with his mother, where her failed attunement during adolescence was devastating. The therapist reported that the patient felt the psychopharmacologist's "over-prescribing" and "lack of attention" to be the same as his mother's "ignoring" him. He once again felt he could be "dying," and that the psychopharmacologist was as "inept" as was his mother, who could not adequately address his needs. She reported the following about the patient's experience

with the psychopharmacologist who prescribed drugs without accurate record-keeping so that he was able to stockpile enough drugs to threaten suicide.

> He was about 16; he was so depressed and suicidal. He went to his mother and asked if he could go and talk to somebody. She ignored him. He felt he could be dying and was, and he didn't get a response from her. His life depended on his ability to provoke a response from her and he felt he couldn't. The psychopharmacologist's lack of attention to details and prescribing felt the same to him, and this activated all of his anxieties about my responsiveness too. He talked a lot to me about having referred him to someone he described and experienced as inept, like his mother.

Category 3: Splitting

Splitting is a primitive psychological defense which preserves the good by separating, splitting, the good from the bad. With development, one is able to integrate the good and the bad into a whole object. Projection is also involved in this process. Splitting is a defense which is often used in a re-enactment. In a reparative experience the split would be integrated. In this study splitting is defined as those times when the patient sees one professional as good and one as bad. This kind of division may remain constant or may shift back and forth from one professional to the other. One professional may be viewed as good all the time and the other as bad, or each may be viewed as good and bad at different times. This is always coming from the patient's experiential perspective.

Splitting was seen by several of the therapists in this study as the patient's need to divide the two professionals, to keep them apart and prevent them from working together. In this interpretation of splitting, the patient, like the child, is seen as having a sense of power at being able to separate the "parents."

One therapist said her patient used the defensive mechanism of splitting throughout his life, and therefore she was not surprised when he used it with the psychopharmacologist.

> It was always, he was always talking about either his mother and father against him, or it was his boss and others against him, or his girlfriends and me against him, or sometimes it was me and him or others against someone else, so when this happened with the psychopharmacologist, it just seemed like it was his style.

This patient was always seeing people as one against the other or two against him, thus splitting the object or objects, never seeing them as whole.

Another example of splitting is seen below when this respondent pointed out how she got different feedback from her patient than the psychopharmacologist did. This respondent felt the patient told her and the psychopharmacologist two different things in order to keep them apart.

> Every time I would get feedback from the psychopharmacologist that he [the patient] was in a good mood and he seemed to be doing much better, he would report to me that it was just because, you know, that day because he was really feeling crappy, but that particular day at that particular moment he was feeling good. I felt like I wanted to kill him.

What follows is an example of how the movement from the good to the bad object can easily shift.

> The psychopharmacologist had profound and far-reaching consequences on the transference. I mean, you know, she messed up, and this re-affirmed his belief that he couldn't trust, that he couldn't get close to her or to me. He saw us as both bad for a while, and then I became good again, but she stayed bad and he refused to see her.

This next therapist saw her patient as experiencing the psychopharmacologist and herself with much the same "disparity" as he had experienced between his parents as a child, with one parent always being all good and the other always being all bad.

> We talked about splitting. About how he split the psychopharmacologist and me and how the splitting in his family between his mother and his father left him with a sense of enormous disparity between that way that his mother and his father were as human beings.

This same therapist went on to say how important it was for her patient to be able to distinguish the present from the past, that is, distinguished by the dyad of the psychopharmacologist and the primary therapist from the original "parental couple." She expressed the importance of his seeing that they were not divided or apart, all good or all bad, even though he had problems perceiving the present clearly.

> It became important for him to see that we weren't a good guy, bad guy here, even though in his own mind that's what he had created.

This last example highlights the back and forth motion that exists within the patient's psyche when this good/bad division occurs between the professionals involved. This respondent very exquisitely illustrated the dynamic of splitting when she talks about her patient as sometimes seeing her and their treatment as all good on one given day, and then on another occasion, seeing the psychopharmacologist as the only valuable professional that exists, as if only one person, not two, can be good.

> He warned me that I shouldn't send anyone else to him. He'd have good days where I was all good, idealized and perfect, and then days when I was no good, and he'd only talk and/or listen to what the psychopharmacologist said. He'd see everything as biological at those times, completely disregarding our relationship and our many years of work together.

Theme 3: Therapists' Inner Process

The respondents were asked to describe how they intervened or handled the therapeutic process as a result of the perceived changes in the relationship with the patient. Most of the participants talked about their own internal feelings and reactions, as

opposed to their patients' or the psychopharmacologists' feelings and reactions or how they intervened or handled the therapeutic process.

Three categories were identified within this theme as part of therapists' inner process: relief, feelings about collaboration, and feelings of self-worth.

Category 1: Relief

Four of the therapists spoke of a sense of relief at having someone else with whom to share the responsibility of their patient. Relief occurred when the psychopharmacologist took over the medical role, and the therapist was able to concentrate solely on the psychological aspects of the patient's problems. Relief, in this study, is an emotional feeling, a sense that one is not alone anymore. The therapists described their sense of relief in the following ways: feeling less personally anxious and less pre-occupied with the patient; feeling calmer, more reassured, and an increased sense of confidence; and feeling less stressed. What follows is an example that clearly illuminates the therapist's "relief" at being able to do her "job" as the psychopharmacologist is doing his/her job. This sense of relief is seen when the respondent states that "she felt relieved" not to have to think about everything herself, to be able to let the psychopharmacologist think about that which she felt less knowledgeable in.

> I was relieved not to have to think about what was biological and what was psychological. I could let the psychopharmacologist do that, and she [the psychopharmacologist] saw me as attending to the clinical work.

The next participant also speaks about "relief." She says "it just felt better" to have the psychopharmacologist sharing the responsibility of her case. She felt better

getting some help and more comfortable being part of a "well-oiled" pair or "working unit," a "two parent family," so to speak. She said

> I was relieved for my patient to finally get some help, more of a floor, and for me to have someone to talk to about some of my hunches. I liked having two people involved. It just felt better.

In the next two examples the therapists were feeling overwhelmed and therefore glad to have assistance. They felt that sharing the responsibility of a case with the psychopharmacologist helped reduce their level of stress.

> Anybody who could help her was fine with me. I was extraordinarily relieved to be sharing this burden with someone else.

Category 2: Feelings About Collaboration

In addition to the emotional feeling of relief that came from the sharing of responsibility, the respondents also spoke about collaboration, an intellectual sharing of thoughts and ideas about the patient.

Four of the therapists in this study were glad to have the psychopharmacologist to discuss their patient with. They were glad to have someone to bounce ideas off of and to get a different point of view. They liked the intellectual dialogue whether or not they agreed or disagreed with the psychopharmacologist. Four therapists spoke of liking the collaboration. They felt that they and/or their patients benefited by having two professionals involved. One therapist emphasized the need for collaboration in spite of the fact she described a negative experience. In this case the respondent described a situation in which the psychopharmacologist was not careful enough about prescription refills, which allowed the suicidal patient to stockpile too many drugs, thereby having a means to commit suicide. While this particular experience was negative, this therapist

spoke at length about how the lack of a "good" collaborator in this situation taught her a great deal about "liking assistance with her thinking, when it works."

> I think probably that initial experience with the psychopharmacologist had profound and far-reaching consequences on the course of the way our relationship developed over its entirety. I know in some ways this first experience was negative and repetitive for this patient; it certainly showed me how much I need to know the consultant better, but also how much I do like having the assistance with my thinking when it works well.

Another participant quite directly speaks about liking to share ideas and "have someone to confirm some of my hunches" with.

> I was relieved for my patient to finally get some help, more of a floor, and for me to have someone confirm some of my hunches. I liked having two people involved.

One therapist felt less burdened by having consultation. She had been "worried" about her patient and felt comforted by having someone to share her thinking with. This can be seen when she states

> I was very appreciative of the psychopharmacologist. I was relieved for the collaboration and support with this case. I was glad to have my suspicions of something more, perhaps something biological, confirmed.

Category 3: Feelings of Self-Worth

Referring their patient for medication brought up feelings of both personal and professional self-worth. Five of the therapists talked about feelings of inadequacy. They wondered if in some way they had failed their patients either by not knowing enough, by misdiagnosing, and/or by not referring soon enough. For some, the referral activated feelings of being inferior to a medical doctor. For these therapists, lack of medical knowledge, training, and status caused them to devalue and/or distrust themselves and

their therapeutic work. Other therapists felt that if they needed to refer to a psychopharmacologist, that meant they had failed as a clinician.

In the following quote, the therapist's sense of lacking knowledge and sense of being "less than" is illuminated.

> I see it as an area of expertise that I can never have and never provide. Now, I understand intellectually that that's fine, but it does bother me about me. Once again it's, you know, having been raised in the medical model. It makes a big difference. Forever for me it is a little bit like being a collaborating social worker [as opposed to the primary therapist].

One respondent talks about her sense of her own limitations, her own sense of inadequacy.

> It is forever imprinted on me that there is this one attribute that another professional has that I will never have.

She also talks about feeling glad to have someone help with the areas she feels a "gap" in, in her own knowledge base, a sense of her own inadequacy in the pharmacological arena. She said

> Generally, I feel relief to have collaboration, but it also does make me aware of a gap in what I'm able to provide for the patient.

The next respondent, who has seen her patient five times a week for six years before referring for medication, expressed her fears about her own competence when she said

> I thought I'd be seen as inadequate, especially for not referring sooner.

In addition to her fears of being seen as inadequate, this therapist was also fearful that she had missed something "diagnostically."

> I was initially fearful of being criticized for not referring her sooner or for somehow missing the boat diagnostically, but the psychopharmacologist was not at all judgmental.

Another therapist who had been trained at a time when medication referrals were considered psychotherapeutic failures said

> I really felt I'd be seen as a failure since I had to refer for medication.

This final example shows a therapist doubting herself, feeling a sense of inadequacy based on the input and feedback given by the psychopharmacologist.

> I started wondering if I'm not dealing with something, you know, directly enough that I should be dealing with, and so then I started having doubts about myself and I started to wonder if I should be tougher.

Theme 4: Working Relationship

When discussing their need for collaboration with the psychopharmacologist, the participants spoke of the need for boundaries, communication, and respect. These three principles are necessary for an effective working relationship, which is the fourth theme of this study.

When discussing the impact that the psychopharmacologist had on the therapeutic relationship, all of the participants in this study agreed that it was the quality of the relationship between the therapist and the psychopharmacologist, or the working relationship, that made the difference.

A good working relationship meant there was a good fit between the psychopharmacologist and the primary therapist. They got along well together. The respondents spoke about three major qualities that were necessary in order for the new triangular relationship to work effectively: the need for boundaries, the need for open lines of communication, and mutual respect between the therapist and the psychopharmacologist.

Category 1: Boundaries

Four of the therapists spoke of boundary issues as they related specifically to the introduction of the psychopharmacologist. They felt that it was of prime importance that the psychopharmacologist keep a clear dividing line between his/her work and that of the primary therapist. The spoke of "the psychopharmacologist knowing his limits and not doing clinical work." They believe that if everyone knows what their role is, each with its inherent limitations, the triangular relationship runs more smoothly, and, generally, the material that emerges for the patient can be seen as symbolizing issues that need to be addressed psychotherapeutically.

This first example states this simply and directly. The therapist was speaking of why she felt the triangular relationship worked when she said

> It worked because the psychopharmacologist understood her boundaries so well, it ultimately benefited my patient's psychological growth.

The next example was given as the therapist was talking about what potential pitfalls she feels can occur with the addition of collaboration and why she feels it did not occur in this situation:

> The potential for splitting was here, but because of the fit between all of us, my boundaries and the psychopharmacologist's boundaries and the close collaboration, it didn't occur.

Another therapist emphasizes the importance of understanding and agreeing upon the boundaries of the two professionals involved. She said

> It's important for the psychopharmacologist and the therapist to agree what the boundaries are. In terms of the therapist's relationship with the psychopharmacologist, I do feel there needs to be clarification and boundaries.

Finally, one therapist talks about the destructive effects of competition that can occur if boundaries are not clear.

> She had boundaries. I mean, she didn't try to make interpretations or interfere with the treatment. Where there's a lot of competition between the psychopharmacologist and the psychotherapist or psychoanalyst, there are insurmountable problems with the consultation and for the patient.

Category 2: Communication

This category refers to an ability of both professionals to talk openly to one another. Three of the participants spoke of the importance of being able to talk with the psychopharmacologist about their own concerns when their patients were unable to speak for themselves. One spoke of "a feeling that the psychopharmacologist talks to you and you to them as necessary with openness and regard." Another participant illuminates this idea when she states

> There needs to be space for everyone to talk about any feelings that come up, no matter whom they are towards.

Another respondent talked about the need for open lines of communication between all involved parties. When she reflected on the psychopharmacological referral, she stated

> There were times we needed to clarify things and communicate, about boundaries, about the patient's history, about anything that came up.

In the next example, it was the primary therapist's intervention with the psychopharmacologist that allowed the psychopharmacologist to act appropriately with the patient. She said she had to explain her patient's experience to the psychopharmacologist because the psychopharmacologist had difficulty believing her patient. This therapist said

> There's another issue that's been operative in this case. That has to do with how important it's been that the psychopharmacologist and I work well together, have a good "fit." I don't know if this is always the case, but with this psychopharmacologist and this patient, I often had to run interference, call and explain what I saw going on, and then the psychopharmacologist would respond more appropriately to my patient.

Another participant described the communication between herself and the psychopharmacologist as follows:

> I could run into him. You could, you know, have a little chat about the case, and so I kept, we kept very close contact, which was nice.

This same therapist continued to talk about her relationship with the psychopharmacologist and the sense of mutuality that existed between them, particularly in relation to "communication."

> I think if he had a thought about what was going on with her, he would tell me, or had I thought of something that going on with her, I would tell him.

Category 3: Respect

"Respect" refers specifically to the therapist's regard for the psychopharmacologist and the psychopharmacologist's regard for the primary therapist and the analytic work that is being done. This category is most clearly captured by one respondent when she said, "He clearly has a lot of respect for me and the work we're doing as I do for him." All of the participants were in agreement that without a mutually respectful alliance, the consultation became too problematic. One therapist expresses this when she said, "There is something about the way he and I resonate as people that really works and allows the triangle to work really well. He never steps on my toes and I never step on his toes." Another common ground for agreement among the participants was expressed by this statement: "I think you have to feel like the person that's doing the

meds is on your side." Respect was captured by one therapist when she reported the psychopharmacologist's feedback as glowing and complimentary of her work with her patient and her skills clinically. She reported the psychopharmacologist as having said

> I can't believe the change. I know some of the drugs have helped, but I really hand it to you for this guy is so hard to work with, I don't know how you do it. He is so negative and so rigid.

One therapist talked about feeling respected when the psychopharmacologist acknowledged her own role as well as the role of the clinician. She said

> I liked when the psychopharmacologist said to my patient, "I am involved with you as your psychopharmacologist, and Dr. _____ is your therapist. You need to tell both of us about side effects, but you need only to tell her about your emotional state."

The next respondent said she values respect when she spoke about the psychopharmacologist knowing his role and having regard for hers. She said

> He doesn't interfere with my work and I don't interfere with his. I certainly would not feel comfortable with a psychopharmacologist who had a theoretical bias toward medication as the answer to everything.

Finally, what follows is one therapist's description of the type of regard she felt must exist between the two professionals involved in this match if the triangular relationship is to work.

> I think the psychopharmacologist needs to not be demeaning or usurping of you in any way. He really needs to have regard for you. He must respect you and see you as another professional.

Summary

The psychopharmacologist appears to be a welcome collaborator whose presence in creating the therapeutic triangle is seen as an opportunity to create psychic repair for the patient. In the six cases reviewed, the introduction of the psychopharmacologist had a

very positive impact on the therapeutic relationship. It provided emotional support to both the primary therapist and the patient; it created a family-like triangular relationship between the patient, the therapist, and the psychopharmacologist, which allowed some of the patients to work through past life situations.

Prior to the introduction of the psychopharmacologist, all of the therapies were stuck and going nowhere. The patients were so paralyzed by the biological aspects of their illness that they were completely unable to utilize therapy, and both the patient and the therapist were feeling inadequate and incompetent.

The addition of medication allowed the patient to use therapy more effectively. The addition of the psychopharmacologist to the therapeutic dyad created a "parental couple," which gave the patient the opportunity to directly deal with some early childhood issues. In addition, when the therapist and the psychopharmacologist had a good working relationship, both the therapist and the patient benefited from the emotional, as well as the medical support, provided by the psychopharmacologist. While most, if not all, of the themes and categories are discussed in the literature, the idea that the psychopharmacologist/psychotherapist dyad potential works as a positive/historical repair for the patient has a whole new angle to it. Chapter V will pull together and detail all of the findings in more depth. Recommendations for future research and limitations of this study will also be described in Chapter V.

CHAPTER V

DISCUSSION

The purpose of this study was to examine what happens to the relationship between the patient and the therapist in an ongoing psychoanalytic psychotherapy when a psychopharmacologist is introduced to medicate the patient. This study was designed to examine the therapeutic relationship from the therapist's perspective, exploring the therapist's thoughts about what happened to the relationship with a particular patient.

It was the researcher's postulation that much occurred in the transferential/ countertransferential realm when a psychopharmacologist was introduced. The researcher believed this to be particularly true in therapeutic relationships that were deep, long term, and had a high frequency of contact between the patient and the therapist within a given week. As noted by Busch (1998), "From the initial consultation, medication becomes another presence in the room. When the decision to medicate is made, and sometimes even when it's not, medication and its effects on the therapeutic relationship remain leaving a lasting impact that needs to be dealt with and understood in an open and analytic way."

Starting with this idea, the researcher asked therapists what actually happened for them and their patients when a psychopharmacologist was introduced into an ongoing psychoanalytically oriented psychotherapy. The findings described in Chapter IV exemplify and delineate the occurrence of transference and countertransference issues as well as highlight why some therapists make referrals for medication and what some of their internal thoughts are.

Review of Findings

Four major themes were identified in the data analysis. The first theme, "Is anything happening here?" related to the first question asked, "What is going on in the relationship between the patient and the therapist at the point at which the therapist starts thinking about making a referral for medication?" The second theme, "parental couple," developed in response to the second question, "How was the relationship impacted by the introduction of the psychopharmacologist?" The final interview question, "How did the therapist intervene or handle the therapeutic process as a result of the perceived changes?" produced the theme of the "therapists' inner process." It was out of the therapists' discussion of their need for collaboration that the fourth theme of the "working relationship" was identified. The effect of introducing a psychopharmacologist into an ongoing psychoanalytically oriented psychotherapy will be discussed in each theme.

Theme 1: Is Anything Going on Here?

The decision to make a referral to a psychopharmacologist during an ongoing psychoanalytic psychotherapy is frequently a complex one. It involves not only the patient's diagnostic picture, but the therapist's biases about medication as well. Based upon the qualitative research conducted for this study, it is apparent that a combination of the primary therapist's and the patient's subjective experience of how the therapy is moving is a large determinant of whether a referral is made.

All six of the participants evidenced much thoughtfulness, care, and deliberation when thinking about making a medication referral. By speaking with each respondent, it

became clear to the researcher that these particular psychoanalytic psychotherapists consider the relationship between themselves and their patient and the depth of the treatment process before they consider a medical consultation. For these therapists, the idea of a medication referral is an extremely complex one.

In this study four of the participants reported thinking about and/or sending their patients for referral when they were questioning whether or not anything was going on within the treatment process. They described little if any movement in the analytic work, typically describing this situation in terms of a feeling on their part or their patient's part that they were "stuck."

All of the therapists reported that they referred their patients for medication because of an "impenetrable" or "intractable" quality to their depression or anxiety, a sense that nothing could get in, nothing could get through. They also described situations where the patient seemed without anything to serve as an anchor; "there was no emotional floor." The characteristic of being stuck, as described by the respondents in this study, seemed similar to that reported in the literature by Wylie and Wylie (1995), who talked about therapists referring due to "non-psychological obstruction factors which prevented analytic work from taking place" (p. 192).

Historically, and to some extent presently, psychoanalytic thinking has seen referral for medication as a treatment failure. This is in contrast to clinicians who work in a more supportive psychotherapy mode and who are more apt to refer for medication. Dr. Martin Willick (1992) talks about this issue of medication referral being a delicate balance when he says that he has seen many patients taken into analytic work, but due to lack of improvement during the course of treatment, the question of medication arises.

Yet he cautions that "we must also bear in mind that without the proper use of medication some treatments fail, there is a corresponding danger that medication might be introduced too quickly and therefore mistakenly" (p. 13).

In this study, two participants referred within the first year of treatment, three within the third year of treatment, and one after six years of treatment. Of the four respondents who waited anywhere from two to six years of intensive ongoing psychoanalytic psychotherapy before referring, it was only when the patient and/or therapist perceived that no movement was taking place that alternative means were explored. The implication here may relate to the type of therapy explored in this study, where therapists consider the relationship, their patients' feelings, and their own feelings before the patient's biology when considering a medication referral.

In the one case where the therapist waited six years with five times per week of intensive psychoanalytic work before referring, it was primarily due to the patient's wish that "they work things through" without medication. This patient had been in a prior treatment and on antidepressants and had come to this treatment specifically requesting an analyst who would work with her without the use of medication. Here, the therapist was caught in a dilemma of counter-transferential complexity as she felt she was going to be seen as inadequate for not referring sooner on the one hand, and letting her patient down on the other.

Another respondent spoke about learning from past experiences and having not referred in the past because she believed that "in order to be analyzed one had to be prepared to suffer." In this instance she referred her patient after two years of analytic

work, much earlier than in the past for her, and reported that her patient was able to function both in and out of the therapeutic realm more effectively.

Two more of the therapists referred after one to two years of treatment feeling that "impenetrable, intractable" sense of no movement in their work with their patients. The last two therapists referred rapidly, one immediately and one after a few months, because of their fears about suicide and the patient's safety. In one case the referral went smoothly leading to "relief" and being able to get therapeutic work done. In the other situation, a "poor fit" and an "unattuned psychopharmacologist" complicated the referral.

How one balances one's belief in the process of psychic change through the analytic process, yet makes an appropriately timed referral for medication operating in our patient's best interests, is a difficult dilemma. This is seen by the therapist who tried for six years to accommodate her patient's desires before referring. This example highlights how the patient's beliefs about medication are an important factor that can further complicate the referral picture. Who makes the decision for referral, when should the therapist inform the patient about their thoughts about the possibility of a referral, and whose choice it is are all ultimately issues that further complicate the medication referral picture.

Community pressure, training, and cultural biases also seemed to have influenced four of the therapists in this study. This is seen in the example of the therapist who felt more comfortable referring now, as she no longer believed that a medication referral meant a "treatment failure." In this study all six of the respondents felt that it was the combination of the psychoanalytic psychotherapy and medication that was effective for their patient, not the medication alone.

What the researcher felt from reviewing the data and talking with these therapists was that medication referral in a psychoanalytic psychotherapy is a complicated decision that all the respondents struggled with. It was very hard for any of these therapists to differentiate with absolute certainty between what was transference, what was countertransference, and what was happening biologically with their patient. It seems that when the therapeutic relationship is perceived as stuck, "not moving," and they know things are not working, then they refer. What also seems clear is that there is no formula for referral. Each therapist took into account not only the patient's diagnostic assessment, but also each patient's uniqueness of the specific therapeutic process.

Theme 2: Parental Couple

"Parental couple" in this study refers to the therapist and the psychopharmacologist working together for the good of the patient, in a manner analogous to a mother and father, despite the patient's perception of what was going on. The categories in this theme are repair, re-enactment, and splitting. The respondents described the repair experience in a different and more positive way than they did either re-enactment or splitting. In repair, healthy change can and does take place due to the development of this new "parental couple."

From four of the respondents reported in this study, it seemed that their patients felt that they were very much included in this new "parental couple" and "cared for in a new and different way" that allowed them to grow, recover, and "repair" old wounds. Perhaps this is best exemplified in the following quote:

> For her the introduction of the psychopharmacologist, perhaps because of her youth, created a familial environment and it felt like, on the one hand,

> she had two healthy, well-functioning parents on whom she could lean, not feel like she burdened them, which was so unlike her own parents that it supplied her with a kind of alternative family. She saw me as an effective mother and the psychopharmacologist as a father she could stand up to and not feel helpless, as she had with her biological father.

Four of the therapists reported their patients as having a sense of "repair" that occurred from the addition of the psychopharmacologist. One therapist said that her patient felt that she had a "male parent as well as a female parent." Another reported that her patient found the psychopharmacologist's thoughts about her intelligence validating in a way her father's had never been. Two said their patients spoke about them, the primary therapist, being the "trusted mother" or "effective mother" who could work in harmony with the psychopharmacologist, the father. According to one therapist, both professionals felt the referral was a "good, solid, reparative" experience for the patient, so much so that the patient left the primary therapist and began seeing only the psychopharmacologist for both medication and psychotherapy. The researcher, however, was unable to obtain sufficient information indicating that this transfer was discussed thoroughly with either the patient or the psychopharmacologist to know whether or not it was actually beneficial for the patient.

The same four therapists reported that their patients had a sense of healing old wounds and scars after the addition of the psychopharmacologist to the therapy situation. The researcher determined from the participants' responses that the therapists considered the triangular relationship reparative and growth-producing in a way that might not have occurred as quickly or effectively had only the dyadic relationship existed. The role that the medication itself played was not looked at or addressed in this study.

It is also this researcher's speculation that the therapists' openness to their patients' experience of the psychopharmacologist on a literal, reality level also played a role in this sense of "repair." Therapists were called upon to decide when a patient's perception of the psychopharmacologist was transferential and when it was an accurate reality perception of the person and/or the situation. The therapists' validation of their patients' accurate perceptions of the psychopharmacologist when it was a "poor fit" was very reparative. In addition, being "listened to," the patient by the psychopharmacologist, was a new experience for many of these patients. Therapists reported that their patients felt this sense of two parents who now worked differently and cooperatively together, which created a feeling of repair when the referral worked well.

An example of how sometimes the problem is with the psychopharmacologist and/or the "fit" can be seen by one therapist when she reports

> He was about 16; he was so depressed and suicidal. He went to his mother and asked if he could go and talk to somebody. She ignored him. He felt he could be dying and was, and he didn't get a response from her. His life depended on his ability to provoke a response from her and he felt he couldn't. The psychopharmacologist's lack of attention to details and prescribing felt the same to him, and this activated all of his anxieties about my responsiveness too. He talked a lot to me about having referred him to someone he described and experienced as inept, like his mother.

This example highlights transference implications (discussed in Chapter IV) as well as reality implications. This therapist reported that the psychopharmacologist was literally remiss in her record-keeping and follow-up with this patient. The psychopharmacologist had actually over-prescribed medication that allowed the patient to stockpile drugs and threaten suicide. It was important to understand the patient's distrust, discomfort, and dislike of this psychopharmacologist as a sound reality assessment as well as transferential situation.

All six of the therapists spoke about how combined treatment influences the therapeutic relationship. Introducing a new person who has distinctive attributes of his or her own will impact the patient. This is clear when one therapist spoke about how her patient saw the psychopharmacologist as "odd," or another when she said her patient "warned her not to use this woman anymore." Another therapist talked about how her patient "flirted with the psychopharmacologist and valued his male opinion," while another spoke about how her patient felt the referral was an opportunity to "work with a father who was not so controlling."

Pizer (2000), in her paper on routine consultations, states, "Enactments, then, are inevitable, inescapable, and even—in the view of many contemporary theorists—a necessary component of vital analytic work" (p. 198). This thinking supports the idea that all that goes on once a therapeutic triangle has been formed can be used to help the patient further his/her own psychic understanding and thus grow and change. In the current study this was observed in the report of a patient's fears that the psychopharmacologist will become her "over-powering father." Likewise, the patient, who was described as perceiving the psychopharmacologist as "odd and disorganized," also illustrates this. Finally, one therapist tells us of a powerful transference enactment when she spoke about her patient wanting them to be the perfect "mommy-baby" pair, having/needing no daddy or any other at all.

Contemporary psychoanalytic thinking views transference/countertransference encounters as potential growth situations for both the therapist and the patient (Stolorow, 1994). This whole theme of the "parental couple" has implications that are quite far reaching when considering patient growth through therapeutic experiences. To the

researcher this theme implies the possibility of using the combined treatment and its inherent triangle as a means of understanding more about the patient's history. In addition, understanding the meaning the patient attributes to the psychopharmacologist may provide the possibility of "working through" and "repair."

Theme 3: Therapists' Inner Process

The theme of the therapist's inner process incorporates the therapist's internal experience of their patient, the referral, the psychopharmacologist, and the entire triangular process as well as their own feeling of self-esteem, as Gitlin (1990) suggests is necessary in order to integrate the consultation procedure into the psychotherapy and keep the psychoanalytic relationship intact. The six therapists in this study were prepared to explore their patients' reactions and their own reactions in an open and respectful manner.

For all six of the participants, this meant being able to use their own experience to begin to think about their patients' potential biological issues. For all of them, the sense of feeling "stuck," "things not getting in," "having no emotional floor" led them to think about a referral for medication for the patients being discussed in this study. The researcher does not know how these therapists think about other patients.

Four of the therapists felt a sense of "relief" and "collaboration" once the referral was made to the psychopharmacologist with whom they had a good "working relationship." The researcher does not know what these therapist felt in other situations when they referred patients for medication.

Five of the therapists spoke of some feeling of inadequacy, worrying that they had failed their patient by not referring sooner or by not knowing enough. One therapist in particular spoke a great deal about having believed that if she referred, it meant she had failed. What this seems to imply for these particular therapists with these particular patients and psychopharmacologists, is that collaboration and relief are welcome side benefits to referring, even though some sense of a lack of self-worth may become activated.

Theme 4: Working Relationship

The fourth and final theme identified in this study is the working relationship, which is based on good communication, clear boundaries, and mutual respect. This "goodness of fit" between the psychopharmacologist and the primary therapist is analogous to two parents in relation to the patient. Kelly (1992) emphasizes teamwork and uses an analogy of how, in a healthy home, each parent conveys respect for the other and for the child, but that does not necessarily mean that their personalities, functions, or views are identical. This fairly accurately sums up what respondents had to say about how they worked with the psychopharmacologist. They needed good communication, clear boundaries, and respect for one another. This is most clearly seen in the following quote:

> There were times we needed to clarify things and communicate, about boundaries, about the patient's history, about anything that came up.

Much of the literature (Busch & Gould, 1998; Finkel, 1998; Jamison, 1991; Klerman, 1991) talks about the importance of the "goodness of the fit" and how it

determines how comfortable a patient is to express his or her concerns, thereby, allowing the professionals involved to better assess the patient's needs.

Four of the participants spoke in varying ways about the need for clear boundaries, mutual respect, and good communication between themselves and the psychopharmacologist in order for the triangular relationship to work well. They referred to this experience as "a working relationship." In contrast, some of the respondents spoke of difficulties they encountered with psychopharmacologists who minimized the role of the analytic work or who saw or understood the patient through a different lens than the primary therapist did. Whatever the encounter, positive or negative, it seems clear to the researcher that communication, boundaries, and respect helped to minimize the problems that can arise when this complex triangular relationship is put into action.

Implications for Clinical Social Work

The results of this study have three main implications for clinical social workers. Number one, many clinical social workers in the analytic community are still hindered by outdated beliefs about the use of psychotropic medication. Number two, many clinical social workers still feel like second class professionals when they are a part of a treatment team. Thirdly, care must be taken in selecting the right psychopharmacologist to become part of the treatment team.

The clinical social workers in this study were trained to believe that psychoanalytic psychotherapy was a deep and curative method of treatment in and of itself, and that the use of medication would interfere with the analytic process. Many of the therapists talked about feeling inadequate or like a failure when they needed to refer

their analytic patients for medication. In all six cases the referral helped, rather than hindered, the progress of therapy. The introduction of the psychopharmacologist had a very positive impact on the therapeutic relationship. It provided emotional support to both the primary therapist and the patient; it created a family-like triangular relationship between the patient, therapist, and the psychopharmacologist, which allowed some of the patients to work through past life situations. Hopefully, the outcome of this study will help change the inaccurate belief that some psychoanalytic social workers still have about combining psychotropic medication with analytic psychotherapy.

In the past, before clinical social workers were licensed for independent practice, they worked under psychiatrists and were considered second tier therapists. When confronted with the need to refer for medication, several of the social workers in the study felt "less than" and as if they had "gaps in their knowledge." In this study the clinical social workers were considered the primary therapist and were treated as equals by the psychopharmacologist. It was the working relationship between the clinical social worker and the psychopharmacologist that proved to be beneficial and reparative for the patient. Hopefully, the results of this study will help clinical social workers appreciate their own strengths and not feel threatened by others' expertise.

In addition, many therapists have had the experience of referring a patient for medication and having the psychiatrist take over the treatment. Potentially, this can have a negative impact on the patient as well as the clinical social worker. Hopefully, the results of this study will help all mental health professionals understand the importance of a good working relationship and will alert clinical social workers to the necessity of carefully

selecting an appropriate psychopharmacologist, one who can work collaboratively and respectively with the primary therapist.

Limitations of the Study

The participants in this study were quite homogenous. All were psychoanalytically oriented, all had practiced many years, all were female, all were graduate level social workers, and all were Caucasian. The sample size was small and non-random; therefore, generalizations to the overall population of patient/therapist/ psychopharmacologist teams cannot be made.

The researcher's acquaintance with the respondents on a collegial level may have created a bias that would not have existed if the participants selected had been more anonymous.

It is possible that a different researcher with a different group of respondents might identify different thematic elements within the therapeutic phenomenon studied.

The idea of therapists' attitudes and beliefs kept coming up as an influential factor as to how, when, and if referrals for medication were made. The therapists' attitudes and beliefs were based on their perceptions of their patients' reactions and feelings, their perceptions of the movement within the therapeutic process, and their assessment of their patients' states emotionally. One would have to consider the high level of subjectivity involved in their evaluations and wonder whether or not their assessments were colored by their own counter-transferential reactions.

For the purposes of this study, only the perceptions of the therapists were examined. Due to the interpersonal nature of the therapeutic relationship, the perceptions

of the patient as well as the psychopharmacologist would be needed in order to round out the picture of what goes on in this area of therapy. Additionally, this researcher believes that the study interview, in and of itself, may have had an influence on the respondents' perceptions of the relationships the study attempted to describe, and that would be of importance to examine as well.

Additionally, it occurred to the interviewer that it would have proven interesting had questions regarding side effects been explored more fully. None of the respondents mentioned significant side effects, and the researcher is unclear as to why this is. Despite the newer psychotropic medications available today, side effects from these drugs can become an issue in and of themselves, and would therefore warrant further investigation.

Recommendations for Further Research

This study represents a real beginning into a rich and exciting field that is burgeoning with information, but has a dearth of scientifically reliable research available. Additional studies should be done using patients and psychopharmacologists as respondents to then see what, if any, similar themes emerge. Likewise, a similar study involving a different sample of therapists would add to our understanding. It would also be interesting to use a larger sample size and to analyze demographic material and present diagnostic pictures on all of the patients, as well as theoretical biases of both the psychopharmacologists and the primary therapists.

All of the recommendations stated above are suggested in the hopes of broadening our scope and understanding of the introduction of a psychopharmacologist into an

ongoing psychoanalytic treatment and, thereby, improving our ability to assist patients who need medication as well as psychoanalytic psychotherapy.

Conclusions

In summary, this study examined the relationship between the patient and the therapist in an ongoing psychoanalytic psychotherapy when a psychopharmacologist is introduced. This study examined this issue from the therapist's perspective. How a therapist comes to think about making a referral, how they feel when the referral has been made, the necessity of a good working relationship, and the potential reparative aspect of the triangular relationship have been explored.

For those patients who need medication, referral can be a positive experience for the therapist and the patient, rather than being considered a "failure." Each therapist has a unique, individual connection with her patient, and these two have an equally unique and individual relationship with the specific psychopharmacologist chosen for consultation. This leaves the researcher to assume that each triangular relationship has to be understood separately, and that even if generalizations could be made, individual assessment would always be of primary importance.

This study was undertaken in an attempt to broaden our understanding of the impact the relationship of the psychopharmacologist has on the formerly dyadic treatment union. In describing some of the elements of change that can occur in the treatment relationship, areas for discussion and further research have been identified. It is the hope of this researcher that the study will stimulate clinicians and psychopharmacologists alike

to think, understand, and talk about what goes on in their combined treatment relationships with patients.

Appendixes

Appendix A.

Introductory Letter

Patricia Antin, LCSW
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Dear Colleague:

I am writing you to ask for your participation in a research study. I am exploring what the therapist's perception is of the impact of introducing a psychopharmacologist for medication into an ongoing psychoanalytic psychotherapy.

I am looking for therapists who are doing long term, psychoanalytic psychotherapy with patients who are on psychotropic medication. I will not be evaluating therapists' work with their patients or their theoretical orientations. I will be looking at the way the introduction of the psychopharmacologist impacted the relationship with the therapist, especially the transference and countertransference issues. I am also interested in how the therapist thinks about various aspects of a patient's difficulties and decides what is biological in nature and what is psychological. What changes need to be made within the psychotherapeutic relationship once the psychopharmacologist is introduced is also of concern. I feel therapists' perceptions about this issue are of great value, and there is a big need for more information about these three areas.

This research study is in partial fulfillment of my doctoral degree and is being chaired by Dr. Alexis Selwood of the California Institute for Clinical Social Work.

The selection of interviewees will begin with the collection of data taken from a Pre-Interview Questionnaire that is enclosed.

If the results of your responses meet the criteria for study, I will be contacting you to see if you would be willing to participate. Participating would involve approximately a one- to two-hour taped interview. As is consistent with research protocol, appropriate measures will be taken to protect confidentiality.

If you are willing to give of your valuable time this way, please complete the enclosed survey, and return it within two (2) weeks in the self-addressed, stamped envelope that is enclosed.

I want to sincerely thank you in advance for your possible participation in this study.

Sincerely,

Patricia Antin, LCSW

Appendix B.

Pre-Interview Questionnaire

PRE-INTERVIEW QUESTIONNAIRE

1. Number of years in clinical practice? _____

2. What is your primary mode of employment? (i.e., private practice, hospital setting, etc.) _____

3. What is your primary theoretical orientation? _____

4. How many times per week do you see most patients? _____

With the thought of one particular patient in mind, please answer the following questions:

1. Have you ever referred a patient for medication? Yes _____
   No _____

   If Yes,
   Was the origin of the referral your suggestion? _____
   Or the patient's? _____

2. How many times per week did you see this patient? _____

3. How long did you see this patient before the medication consult?
   _____

4. How long after the medication consult did you see this patient?
   _____

5. What was your theoretical orientation with this patient? _____

6. Have you received personal psychoanalytic psychotherapy or analysis?
   Yes _____ No _____

7. What post M.S.W. training have you received? _____

8. Are you now receiving clinical consultation/supervision? _____

Appendix C.

Therapists' Informed Consent

CALIFORNIA INSTITUTE FOR CLINICAL SOCIAL WORK

INFORMED CONSENT FORM

I, _____, hereby willingly consent to participate in the research project: What is the Therapist's Perception of the Impact on the Therapeutic Relationship When a Psychopharmacologist is Introduced Into an Ongoing Psychoanalytic Psychotherapy to Medicate? This research is to be conducted by Patricia Kay Antin, LCSW, under the direction of Dr. Alexis Selwood, Ph.D., of the California Institute for Clinical Social Work, principal investigator.

I understand the procedures as follows:

1. I will fill out a brief pre-interview questionnaire.
2. I will participate in an interview of one to two hours, and an audio recording will be made of the interview.
3. I am aware that there is minimal potential risk for emotional discomfort involved in participating in this study. Should this occur, I will be able to contact the researcher, who will make arrangements for me to receive professional help or consultation for a reasonable and limited time.
4. I understand that this study may be published and that confidentiality will be maintained, and that my anonymity and that of my patient will be maintained.
5. I have been informed that an interview with the researcher will be taped for the purposes of data analysis, and at the completion of the study this tape will be destroyed. I realize that I will not be identified in any publication or presentation of information gathered as part of this study.
6. I understand that I may refuse to answer any questions, and that I may withdraw from the study at any time.

Signature _____ Date _____

Appendix D.

Interview Guide

INTERVIEW QUESTIONNAIRE/GUIDE

Introduction

Therapists work with patients in a variety of ways, employing many different theoretical models and personal styles. This study will attempt to understand the impact introducing a psychopharmacologist has on the relationship between the patient and the primary therapist in an ongoing psychoanalytically oriented psychotherapy. Your style and/or orientation are not being studied, but rather what you have perceived happening to the transference and countertransference. Neither you nor your work are being judged, evaluated, or studied. Your perceptions about this issue are valuable and can potentially make a major contribution to the field.

Interview Guide Topics

I. What Indications Did the Therapist Use for Considering a Referral to a Psychopharmacologist for Medication?

This topic begins with an exploration of the therapist's perception of what was happening in the relationship with the patient at the time when the therapist began thinking of making a referral for medication.

The participant will be directed to pick a particular patient with whom they were thinking about a medication referral. They will be instructed to talk about and elaborate on their thoughts and feelings about why they thought a referral was indicated and how they differentiated or thought about what behavior in this patient caused them to think a medication referral was indicated. They will also be asked to talk about their thoughts

and perceptions about when they first started thinking about a medication referral through to when this patient actually started on and began a medication regime.

II. How Was the Relationship Impacted by the Introduction of the Psychopharmacologist?

Here, the researcher wants to explore the therapist's perceptions of how the relationship was impacted, with specific examples and vignettes coming directly and spontaneously from the participants. The researcher is especially interested in the transference and countertransference that occurred in this situation.

III. How Did the Therapist Intervene or Handle the Therapeutic Process as a Result of the Perceived Changes?

What did the therapist observe going on between himself/herself and the patient once the psychopharmacologist had been introduced into the treatment situation?

Here, the participant will be directed to think about a point in time when this patient was actually on medication. Then they will be asked to expound on any changes they noted, particularly as they related to the transference and the countertransference, as well as the relationship as a whole.

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