REVIEW

The integration of psychopharmacotherapy and psychoanalytical psychotherapy: a critical review

Benício Noronha Frey,[a] **Luiz Carlos Mabilde**[b] **e Cláudio Laks Eizirik**[c]

[a]Serviço de Psiquiatria do Hospital de Clínicas de Porto Alegre e Departamento de Bioquímica, Instituto de Ciências Básicas da Saúde, Universidade Federal do Rio Grande do Sul (UFRGS). Porto Alegre, RS, Brasil

[b]Centro de Estudos Luis Guedes e Sociedade Psicanalítica de Porto Alegre. Porto Alegre, RS, Brasil

[c]Departamento de Psiquiatria e Medicina Legal da FAMED/UFRGS e Sociedade Psicanalítica de Porto Alegre. Porto Alegre, RS, Brasil

Abstract

Objective: *Integration between psychotherapy and psychopharmacotherapy has been a conflicting subject in the history of psychiatry. To date, dichotomy between "biological" and "psychological" models is noticed, although recent studies have been showing the importance of the association of these modalities in the current psychiatric practice. This study attempts to review psychodynamic, technical, and other issues involving the integration of pharmacological and psychotherapeutical treatments.*

Methods: *Literature search was based on MEDLINE, PsycholNFO and Lilacs, referring to the period from 1966 to September 2002.*

Results: *The studies reviewed demonstrated that the application of combined treatment might be positive.*

Conclusions: *The efficacy of the combined treatment depends on the capacity of the integration of the different forms of treatment. More research is necessary in this area.*

Keywords*: Psychoanalytic therapy. Psychopharmacology. Combined modality therapy.*

"Major mental illness does not confer immunity from neurotic conflicts"
Donald B Nevins

Introduction

In the last decades, there has been a remarkable change in the attitude of psychoanalysts and psychotherapists regarding the concomitant use of medication during psychotherapy,[1,2] as well as during the psychoanalytical treatment,[3] although the psychoanalytical literature about this issue is scarce.[4]

Before tackling with this movement toward the integration of biological and psychotherapeutical/psychoanalytical treatments,[5] we will perform a brief historical review. At the end of the 19th century, Sigmund Freud, formerly a neuropathologist, developed a model of psychological treatment that revolutionized the understanding of the human mind, which he named psychoanalysis. Even not having a neurophysiological basis for mental disorders, in the work 'On narcissism: an introduction' (1914),[6] Freud already alluded to the integration between biology and psychology*: 'We must recollect that all of our provisional ideas in psychology will presumably one day be based on an organic substructure'*. During the first half of the 20th century, there has been a great progress in the psychoanalytical theory, being the dominant therapy at that period. However, contrarily to the ideas of Freud proper, the research within psychiatry on the *somato* (brain, body, organic) has developed dissociated from psychoanalysis (mind, psyche). In this period, some psychiatrists tried to integrate mind and body theories, standing out Adolf Meyer, a pioneer in the bio-psycho-social model, who sustained the study of the patient *as a whole*.[7] In the '50s, the first psychotropic medications have arisen and, in the following decades, as drugs progressively became to be used in outpatient practice (the domain of psychoanalysts par excellence), the polarization within psychiatry between 'biological' and 'psy-

chological' fields[8] also increased. With the progress of diagnostic guidelines and researching methodology, medicine has become increasingly based on evidence, a territory in which studies with psychopharmacs have undergone an exponential development (with the substantial incentive of resources from the pharmaceutical industry), what has not occurred with psychoanalysis[9] and with psychoanalytical psychotherapy. Therefore, comparatively, analytical therapies little could prove, according to the current scientific methodology, to which point they succeeded to heal, prevent or delay the course of mental disorders, due to reasons that will be better dealt with in this paper.

Actually, the several reasons to support one or other treatment line, an attitude that we may call reductionist,[9,10] are primarily based on theoretical and ideological arguments rather than on empirical data.[11] For years, many (or perhaps most) psychoanalysts have understood neuroses as exclusively 'psychological', understanding as inappropriate or undesirable the 'biological' treatments, as they would cause only the suppression of symptoms, mitigating them, and, therefore, obstructing the exploration of the 'real' problem.[12] Therefore, the medication would not work for the healing, but to favor the resistance.[13] Specialists in pharmacotherapy, in turn, claimed that psychotherapy was unnecessary or even harmful, as they kept patients worried with issues full of unhealthy conflicts.[4] And which would be the advantages of integrating these therapies? Hoffman (1990) stated the need of a unitary treatment model, as mental disorders would always occur under a psychological *and* biological matrix.[1] Reviewing the adjuvant use of medications in psychotherapy, Marmor (1981)[14] and Karasu (1982)[15] concluded that the medications were more useful for the short-term relief of symptoms, allowing the patient to be more accessible to psychotherapeutical exploration. As stated by Bellak et al. (1973): '*For some forms of psychotherapy, and even some forms of modified psychoanalysis, the psychotropic drugs play the role which anesthetics play for surgery: they often constitute the conditions which enable the intervention to be carried on.*'[16] Karasu also concluded that each modality would have different effects and would act at different times during the treatment. The drugs would have their highest effect in the formation of symptoms and in affective alterations and would act earlier, whereas psychotherapy would influence more directly in the interpersonal relationships and in the social adjustment, having later and more protracted effect.[15] In his study on the combined treatment for patients with personality disorders and depression, Marcus (1990)[17] claimed that antidepressants dramatically improved the rapidness and efficacy of psychotherapy, acting on ego autonomic functions, such as regulation and modulation of affects. He stated also that this improvement in ego functions could 'make the difference' between a negative therapeutical relationship, which could destroy psychotherapy and its progress, besides modifying the transference from a psychotic level or, more frequently, quasi-psychotic, to neurotic levels of organization and anxiety.[17]

Donovan and Roose (1995)[18] performed a study which illustrates well the reality of this new movement of integration. Aiming to answer the question: 'how many patients took a medication during their psychoanalytical treatment?', the authors sent questionnaires to all didactic analysts of the Psychoanalytical Training and Research Center at Columbia, US, and demonstrated that two thirds (62%) of analysts had patients using psychotropics in the 5 previous years, what corresponded to 20% of the total of treated patients. For the great majority of patients the analysts considered that not only had occurred the expected therapeutical response to the medications, but also a positive effect in the analytical process.[18] More recently, Guimón et al. (1998)[19] conducted a study assessing the treatment methods of Swiss psychiatrists, and evidenced that 91.9% of psychoanalysts and 95.8% of psychotherapists used medications associated with psychotherapy. However, even nowadays there is tension between the 'biological' and 'psychological' tendencies.[20]

The aim of this study is to perform a critical review on the considerations which involve the use of medications as adjuvant of psychotherapy, emphasizing the psychodynamic and technical aspects of this association, as well as the influence of teaching and research in this field. The methodology used was on-line search on the databases MEDLINE, PsycINFO, and Lilacs, from 1966 up to September 2002. The searching terms were: 'analytic psychotherapy', 'psychopharmacotherapy', 'combined treatment' and 'split treatment'. Inclusion criteria were publications which discussed the combined treatment between psychotherapy, especially psychoanalytical psychotherapy, and psychopharmacotherapy. For its being a relatively unstudied subject, we tried to perform a more comprehensive and less judicious review on the subject, using cross references from the material obtained in the search and indications from the experts (professors/researchers) on the subject. Only articles published in English or Portuguese were included and studies which were limited to the discussion of case reports were excluded. As search results, 43 articles were obtained, having been excluded 16 of them, remaining 27 journal articles. Five references were included following the experts' suggestions, totaling the 32 references of this study, according to the illustrated diagram in Figure 1.

Beyond psychopharmacology: unconscious significances

The pharmacokinetic mechanisms and the mechanisms of action of the several psychopharmacs are well known. Moreover, in research it has been known for a long time that

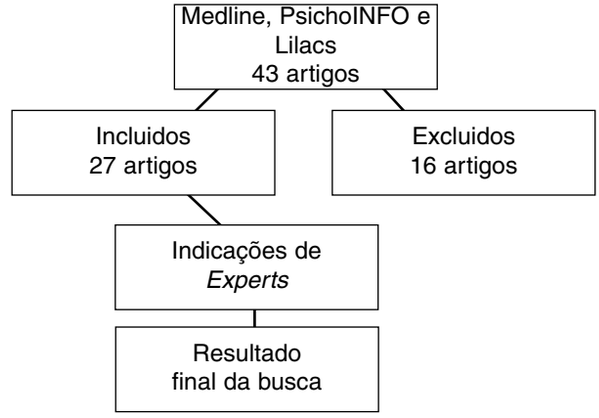

Figura 1 – Diagrama da metodologia de busca dos trabalhos

not all therapists experience the same success in the use of medications, and there should be other factors - not related to pharmacs-, responsible for these differences. The positive response to placebo, which in major depression is nearly 30%, may stem from the situation, the patient's personality, the physician's personality and the 'emotional interaction between them' [transference].[21] In fact, in the prescription of a drug, the transferential phenomenon and the unconscious fantasies may develop under varied forms, and therefore give the opportunity to the psychotherapeutical understanding. For a depressed patient, e.g., the prescription may imply in feelings of punishment, confirmation of self-blaming beliefs, reinforcement of masochist trends or resignation regarding the painful feeling of loneliness and isolation, as the medication could replace the human relationship. For a manic, medication may interrupt the search for reward, remove the creative and grandiose power and risk the feeling of euphoria and well-being which defends the subject from depression.[5]

The medication may elicit the patient's ambivalence. On the one hand, the patient may fear the omnipotent primitive object-physician or fantasize being poisoned, manipulated, seduced or rejected: 'the doctor is prescribing a medication in order to not listen to me anymore'. On the other hand, the patient may believe in a 'magic cure' by the good doctor. He/she may desire to become dependent on the physician, in a childish passive attitude, or understand the prescription as a sign of concern about the father/mother-physician and feel his/her pain as understood. Therefore, the prescription may represent either a narcissistic wound for one patient, or a relief from anxiety and a reinforcement of hope for another one.[4] In 1953, Winnicott described the theory of the transitional object as a stage for the development of a total object relation.[22] After that, Adelman (1985)[23] wrote about the medication as a transitional object. Actually, even flasks of medications or medical receipts may be used as a transitional object, as an aid to deal with the anxiety about the danger of a temporary loss (between sessions, vacations) of the object-physician.[2] The swallowing of the medication may also, partially, represent the internalization of the therapist during the psychotherapeutical process. Patients with trend to somatizations may project in the medication the responsibility for their disturbing feelings (to which we suggest calling 'pseudo side-effect'), or even have them relieved under the suggestion of the medication. Therefore, the transference approach in medicated patients may be determinant to increase or resistance to the effect of drugs.[21] As already seen, the prescription may evoke rich transferential feelings, fantasies and beliefs, which may serve as another aid in the understanding of the internal world of our patients.

Psychodynamic aspects of prescription

The decision of using a psychotropic medication requires a cautious consideration. The psychiatrist should be attentive to the fact that the decision of prescribing a medication may be influenced by his/her own unconscious conflicts and desires. This decision may indicate an incapability of the therapist to endure the (necessary) slowness of the psychotherapeutical process. The psychiatrist may also not be able to tolerate (contain) the painful affections, such as anger and sadness, medicating to relief *his/her* anxiety.[4] Besides, he/she may be acting projectively counter-identified, motivated by desires of seduction, manipulation or seek of rewards from patients. Feelings of ambivalence from the psychiatrist may arise; the clinician may either consciously or unconsciously identify with the patient's feelings or use the medication to remain distant and protect him/herself from the unpleasant feelings caused by this transitional identification.[5] The prescription may, also, exalt the therapist's sensation of omnipotence, causing in the patient anxiety and fear of the omnipotent object-therapist, as well as the formation of a narcissistic collusion (best therapist, best patient). Nonetheless, conscious and unconscious determinants of the therapist may also influence the decision of not medicating and imposing him/herself even when there is a precise indication for the use of the drug. Besides the already-mentioned ideological aspects (reductionist), the therapist's omnipotence, denial or even ignorance may influence his/her decision. Moreover, the therapist may be reluctant to prescribe a necessary treatment due to feelings that this might signify a psychotherapeutical 'failure'.[4] Fear of having his/her role decreased or that the importance of psychodynamics be 'reduced' by the biological one may be also present. According to Kandel (1999),[9] such a reduction is impossible, as these approaches have different objectives and perspectives and would converge only in certain critical points. Other beliefs against the introduction of the medication include: 1) that the medication would be temporary or superficial, not acting on the disease's nucleus, 2) that the medication could have a negative placebo effect, increasing the dependence and extending determined psychopathologies, 3) the relief of symptoms might reduce the motivation to proceed psychotherapy, 4) the medication might eliminate one symptom and create others, if the conflict remain intact, 5) the patient might decrease his/her self-esteem for having 'such a severe' problem that it would not be solved only with psychotherapy and 6) fear of complicating the situation due to the introduction of a '3rd person' (object) in the setting.

The assessment of the patient's philosophies (supposing that the therapist had already assessed his/hers') is perhaps as much important as a cautious clinical assessment to determine an adequate therapeutical modality is. The patient-therapist team may be determinant for the success of psychotherapy in the same way in which the pairing patient-modality may be also an important variable.[24] Whenever introduced a medication, the therapist should explain his/her reasoning, allowing the patient to have time to expose his/her considerations and answer to his/her real concerns. Negative transferential feelings may be expressed by means of complaint about side-effects (in fact, pseudo side-effects). His/her associations, fantasies, dreams and affections would be revealed in the transference, during the process, although the discussion of transference may be difficult as the medication is an established (concrete) fact and the affections originate in the unconscious (less palpable). Besides, forcing the patient into the medication regime may result in a negative transferential reaction and eliminate thus the positive impact of the medication.[4]

Technical issues

After the decision of using medication, another decision is imposed on the psychotherapist: *how* to medicate. Pharmacological and psychotherapic treatments may be used under the form of a combined treatment or in split treatment. In combined treatment, the same psychiatrist conducts both modalities for the same patient. In split treatment,[8] the patient consults two professionals, one for psychotherapy and the other for medication.[25]

According to Busch and Gould (1993),[26] the therapeutical triangle (patient, psychotherapist and psychopharmacologist) may be highly rewarding for all parties, provided it could also promote a fertile field for the development of negative transferences and contra-transferential responses from both professionals. Actually, beliefs and affections may arise early, in the referral. According to Bradley (1990),[27] the referral may be partially a contra-transferential enactment to deal with an impasse in psychotherapy. The patient may interpret this as: 'my therapist is giving me up' or 'my disease is hopeless'. In this phase, negative transferential feelings regarding the psychotherapist may result in a dissociation, in which the psychopharmacologist, due to his/her more active and directive position, added to the relief of symptoms by the drug, becomes the good and idealized object. Such an idealization may be used by the patient as a resistance to the painful transferential feelings in psychotherapy. However, the transferential obstacles may be complicated by the therapists' anxiety, moreover by feelings of omnipotence and competition between them. The psychotherapist may feel narcissistically uncomfortable having to 'ask for help', or to reveal (to the patient or to him/herself) his/her lack of skill to deal with determined situations. The pharmacologist may ally to these negative transferential reactions and form a collusion with the patient, informing, even unconsciously, that he/she may (narcissistically) take care of the case alone. Therefore, the role of each therapist should be clearly defined from the beginning, based on an open and mutually respectful relationship. Periodical discussions are important, mainly at the beginning of treatment, in order that professionals do not act to favor the patient's dissociation. Besides, as the psychotherapist assists the patient more frequently, he/she must be instructed regarding recurrent signs and adverse effects. In specific situations, in which the divergences between the professionals could not be overcome, a supervision or even a change of one of the members may be necessary.

Greene (1998)[3] published one case of analysis in which he had practiced combined therapy and concluded that there are cases in which it is crucial for the analyst to prescribe the medication, as in this modality may occur a specific transferential reenactment, more important than the medication per se. In a treatment in which the same therapist conducts psychotherapy and pharmacological treatment, the ordinary route of these forces is transference. Therefore, we may say that the pharmacological action may modify transference and, although less easily identifiable, transference may modulate the subjective experience of the action of the medication.[13] Other important technical aspect during combined therapy is the difference in the 'optimal distance' from the patient's emotional experience. In psychotherapeutical practice, the therapist maintains a relative proximity to the patient's emotional experiences, whereas in pharmacotherapy, he/she should reason based on the knowledge of physiology and pharmacology, which are more distant points from the patient's emotional life. Therefore, Hamilton et al. (1994)[2] suggested that the therapist should begin the session with a more distant attitude, aiming to review the doses, symptoms, side-effects, etc., and become closer during the session. Last but not least, the discontinuation of the medication should be also extensively discussed with the patient, providing patients the opportunity to express freely their fears and anxieties. The therapist should assure that the withdrawal of the medication does not mean, necessarily, the end of therapy; therefore, it is not advisable that both treatment modalities finish simultaneously.

Teaching and research

Teaching and research are important aspects which directly or indirectly influence the (dis)integration between psychopharmacotherapy and psychoanalytical psychotherapy. Psychiatric residence programs rarely teach combined treatments between the several modalities.[8,28] The supervision of residents is, in general, divided (dissociated) in psychotherapy and psychopharmacotherapy. Consequently, when combined therapy is applied residents may be worried about 'deviating from the orthodox procedure'.[4] According to Lipowski (1986),[10] residents should be taught about multifactorial diagnostic assessment, as well as on the several therapeutical modalities. Moreover, although it may not be expected that all psychiatrists be able to use all forms of treatment, it is expected their being capable of assessing which therapeutical modalities better meet the individual needs of each patient. However, the role of teaching in the different areas of psychiatry possibly reflects the reality found in the research field. How to identify which form of treatment is more efficient for a determined patient? How to assess how much each of these therapeutics contribute for the whole therapeutical process?

Kandel (1999)[9] stated that, although psychoanalysis has, historically, been scientific in its objectives, it rarely has been scientific in its methods. Specifically, objective methods to test the hypotheses generated have not been developed. Most of times, there are only the analysts' subjective hypotheses about what they believe that occurred, and this type of evidence is not well accepted in the more scientific contexts. At this point, Drob (1989)[29] highlights, among others, the theories of commensurability and relativism (incommensurability). Theorists of commensurability sustain that the several theories of psychiatry should prove which is the 'best' or 'most valid', according to a determined criterion of truth, which, currently, is very close to the so-called evidence-based medicine. However, in practice it is extremely difficult to reach a criterion of validity not reflecting the values of one of the tendencies (biological, psychodynamic, etc.) of psychiatry, and acceptable for all of them. According to relativism, never should any criterion of validity be accepted, as each theory depends on the initial hypotheses about human nature, which are not available for empirical testing. Therefore, psychiatry's fundamental hypotheses would be essentially ques-

tionable and the several theories would be, thus, incomparable or incommensurable. Lipowski (1986)[10] reported that, without concepts and tools that allow the study of the human being *in all aspects at the same time,* it would be necessary to resort to methodological reductionism as a strategy. That is, the researcher would deliberately decide to test the variables of only one of the classes, be it biological or psychological, aiming to study the contribution of each of them for the development of a determined disorder. More recently, with the appearance of neuro-psychoanalysis, studies have been performed aiming to experimentally integrate psychoanalysis and neurobiology.[9] Fonagy et al. (2000)[30] conducted a review on the results of psychoanalytical treatment and concluded that: 1) there is no definitive study demonstrating that psychoanalysis is unequivocally effective compared to an active placebo or an alternative treatment method, 2) among the main methodological limitations, they found the selection bias of the sample and the lack of standardized diagnoses, control groups, aleatory indication (randomization)and independent assessment of results (blindness), although 3) many of the studies being developed are methodologically more advanced and up-to-date.

Discussion

The integration patient-psychiatrist is the result of the capability of the therapeutical process to absorb and integrate all data and aspects of the patient's personality, and is the only way to enable the evolution and deepening of the psychotherapeutical treatment. Therefore, the prescription of medications during psychotherapy may bring rich material from the patient's internal world, to be examined in the psychotherapeutical field. Actually, there is a false belief that a psychotropic medication may be prescribed with or without a formally constituted and organized psychotherapy, as a psychotherapeutical relation is created whenever a subject under mental pain seeks a physician and is prescribed a medication; i.e., the act of prescribing is part of an interpersonal relationship.[4]

The articles reviewed in this study illustrate the possibility of integration between the 'biological' and psychological' tendencies, by means of the combination of concomitant psychotherapeutical and psychopharmacological practice. However, as this issue is hardly debated in the academic milieu and the researches in this field are still scarce, consistent and definitive conclusions about the subject cannot be formulated. Prospective, controlled studies, with more representative and better delimited samples, and using valid instruments are needed.

Although knowing that patients are many times self-selective,[8,31] i.e., they search therapists who share the same treatment line they believe (frequently for neurotic reasons), we consider that dealing with mental problems under an exclusively biological or psychological view may be a denial of a more adequate treatment to the suffering subject. One of our challenges is to recognize the complexity and multifactorial character of mental disorders and to seek ways for their integration or, at least, to develop and keep a dialog respecting the specificities of each of them. This goal may perhaps take the time needed for the elaboration of grief for the loss of omnipotence of those who (still) defend reductionism.

We end our study with a statement by Kay Jamison (1996),[32] which may express the feelings of those who treat and those who are treated, following an integrationist approach: '*I cannot imagine leading a normal life without both taking lithium and having had the benefits of psychotherapy*'.

Trabalho realizado no Serviço de Psiquiatria do Hospital de Clínicas de Porto Alegre, RS.
Sponsor: None
Received 22.01.2004
Accepted 25.03.2004

References

1. Hoffman JS. Integrating biologic and psychological treatment: the need for a unitary model. Psychiatr Clin North Am 1990;13(2):369-72.
2. Hamilton NG, Sacks LH, Hamilton CA. Object relations theory and pharmacopsychotherapy of anxiety disorders. Am J Psychother 1994;48(3):380-91.
3. Greene MA. The effects of the introduction of medication on the psychoanalytic process: a case study. J Am Psychoanal Assoc 1998;49(2):607-27.
4. Goldhamer PM. Psychotherapy and pharmacotherapy: the challenge of integration. Can J Psychiatry 1983;28:173-7.
5. Nevins DB. Psychoanalytic perspectives on the use of medication for mental illness. Bull Menninger Clin 1990;54:323-39.
6. Freud S. Sobre o narcisismo: uma introdução, 1914. In: Edição standard brasileira das obras psicológicas completas de Sigmund Freud. Rio de Janeiro: Imago; 1969. vol. 14. p. 89-119.
7. Meyer A. Progress in teaching psychiatry. JAMA 1917;69:861-3.
8. Kahn D. The dichotomy of drugs and psychotherapy. Psychiatr Clin North Am 1990;13(2):197-208.
9. Kandel ER. Biology and the future of psychoanalysis: a new intellectual framework for psychiatry revisited. Am J Psychiatry 1999;156:505-24.
10. Lipowski ZJ. To reduce or to integrate: psychiatry's dilemma. Can J Psychiatry 1986;31:347-51.
11. Rounsaville BJ, Klerman GL, Weissman MM. Do psychotherapy and pharmacotherapy for depression conflict? Empirical evidence from a clinical trial. Arch Gen Psychiatry 1981;38:24-9.
12. Michels R. Medication use during psychoanalysis: a survey (commentary). J Clin Psychiatry 1995;56(5):179.
13. Brockman R. Medication and transference in psychoanalytically oriented psychotherapy of the borderline patient. Psychiatr Clin North Am 1990;13(2):287-95.
14. Marmor J. The adjunctive use of drugs in psychotherapy. J Clin Psychopharmacol 1981;1:312-5.
15. Karasu TB. Psychotherapy and pharmacotherapy: toward an integrative model. Am J Psychiatry 1982;139:1102-13.
16. Bellak L, Chassan JB, Gediman HK, Hurvich M. Ego function assessment of analytic psychotherapy combined with drug therapy. J Nerv Ment Dis 1973;157(6):465-9.
17. Marcus ER. Integrating psychopharmacotherapy, psychotherapy, and mental structure in the treatment of patients with personality disorders and depression. Psychiatr Clin North Am 1990;13(2):255-63.
18. Donovan SJ, Roose SP. Medication use during psychoanalysis: a survey. J Clin Psychiatry 1995;56(5):177-8.
19. Guimón J, Fischer W, Zbinden E, George D. Therapeutic practice profiles, theoretical models and representations of the psychiatry of Swiss psychiatrists. Schweizer Archiv fur Neurologie und Psychiatrie 1998;149:41-50.
20. Eizirik CL. A psychoanalytic perspective on the future of mental

health: current challenges. In: Guimón J, Zac de Filc S, editors. Challenges of psychoanalysis in the 21st century: psychoanalysis, health, and psychosexuality in the era of virtual reality. New York: Kluver Academic / Plenum Publishers; 2001. p. 123-31.
21. Annito W, Kass W. Psychotherapy, psychopharmacology, and the illusion of curing. Bull Menninger Clin 1979;43(6):552-5.
22. Winnicott DW. Transitional objects and transitional phenomena. Int J Psychoanal 1953;34:89-97.
23. Adelman SA. Pills as transitional objects: a dynamic understanding of the use of medication in psychotherapy. Psychiatry 1985;48:246-53.
24. Osório CM. Problemas relativos à concomitância de psicoterapia com psicofarmacoterapia: questões conceituais no campo da psiquiatria. I Congresso Gaúcho de Psiquiatria; 1991 Jul 18-21; Gramado, Brasil.
25. Jakobson V, Carneiro AE, Blaya C, Rocha DL, Prá JD, Fisher M, et al. Co-terapia: estruturação e psicodinâmica do triângulo terapêutico. R Psiquiatr RS 2002;24(1):34-44.
26. Busch FN, Gould E. Treatment by a psychotherapist and a psychopharmacologist: transference and countertransference issues. Hosp Community Psychiatry 1993;44(8):772-4.
27. Bradley SS. Nonphysician psychotherapist-physician pharmacotherapist: a new model for concurrent treatment. Psychiatr Clin North Am 1990;13(2):307-22.
28. Mabilde LC, Kapczinski F, Ribeiro L, Tocchetto A. Considerações sobre o tratamento farmacológico e psicodinâmico dos transtornos de ansiedade. R Psiquiatr RS 1999;21(1):41-51.
29. Drob SL. The dilemma of contemporary psychiatry. Am J Psychother 1989;43(1):54-67.
30. Fonagy P. An open door review of outcome studies in psychoanalysis. 2nd ed revisited. 2002 Feb. Available from: URL: http://www.ipa.org.uk
31. Cohen SK. Psychoanalysis and psychotropic medication. J Am Psychoanal Assoc 1995;43(1):15-6.
32. Jamison KR. Uma mente inquieta. São Paulo: Martins Fontes; 1996.

Correspondence
Benício Noronha Frey
Rua Almirante Abreu, 108/201
90420-010 Porto Alegre, RS, Brazil