Psychotherapy and pharmacotherapy for depression. Regarding a clinical case

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Introduction

For several years there has been documentation (Vaughan *et al.,* 2000) of the inverse correlation between the gravity of depression and the predisposition to adopt an attitude that can psychologically assess the connections between feelings, thoughts and actions. Such an attitude allows access to and thought about the origins and the meanings of subjective experiences. This predisposition, known in psychological terms as *psychological mindedness,* is found to be lacking in the depressed patient, making him less able to get involved in a process of analysing and understanding his own psychological dynamics (Roose & Cabaniss, 2006). In the psychoanalytical context, the use of pharmacotherapy to facilitate the recuperation of *psychological mindedness* at the beginning of psychotherapy or during analysis of a depressed patient has also been recommended for some time. (Roose & Stern, 1995; Cabaniss, 2001).
In a recent monograph (Busch, Rudden, & Shapiro, 2007) the authors reaffirmed and argued the importance of treating people suffering from medium to serious depression disorders using psychodynamic psychotherapy combined with a pharmacological treatment. In this perspective, the elements underlying the process of this choice should include the patient's level of suffering and the degree to which the depression symptoms interfere with his daily functioning and with the psychotherapy process; if the symptoms do not lessen after two or three months of psychotherapy, the pharmacological therapy should be considered at every stage of the decisive process in the psychotherapeutic relationship.
Psychodynamic therapy has the task of exploring both the decision about whether to use the drug, and the conflicts that may derive. The introduction of the drug, in this context, at times seems essential not only to moderate the symptoms of depression but also to enable the psychotherapy to procede, facilitating the detailed exploration of the patient's conflicts. According to Busch, Rudden, & Shapiro (2007), usually the combination of psychodynamic psychotherapy with a pharmacotherapy envisages the involvement of a psychotherapist coordinated with a psychiatrist, giving rise to a so-called "triangular treatment" (Beitman, Chiles, & Carlin, 1984; Busch & Gould, 1993; Riba & Balon, 2001), the points of which are made up of the patient, the psychotherapist and the psychiatrist. The "triangular treatment" may encounter serious difficulties, may fail or be interrupted for various reasons: the breakdown of the relationships, the fallout of conflicts on the interventions during the treatment, professional jealousy between the two figures involved. To try to avoid such an outcome it is therefore of fundamental importance for the two professionals involved to keep up constant productive communication, especially when difficulties arise during the treatment.

For the sake of completeness, it should be remembered that Busch, Rudden, & Shapiro (2007) also indicate the possibility that the combination of psychodynamic psychotherapy with the use of drugs may involve only the figure of the physician-therapist. The clinical case on which this article focuses is in fact a concrete example of this very eventuality.

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The results of psychotherapies in depressive disorders as well as the combination of psychotherapy and pharmacotherapy have been examined by in-depth quantitative studies. For an preliminary survey, see for instance Rush & Thase (2001) and de Maat et al. (2008). In Italy Fava (2001) and his group (Tomba & Fava, 2006; Ruini, Tomba & Fava, 2007; Tomba & Fava, 2007; Tomba & Fava, 2009) have repeatedly examined these questions with empirical studies.

We will present a single case, aware of the quantitative limitations but also of the fact that the in-depth study of a single case can reveal problem points and questions that can be further developed, play a heuristic role (Nasio, 2002) and find possible later validations or confutations also on the level of quantitative empirical research.

The clinical case

B. is a 42-year-old man when he consults a psychotherapist for ups and downs, mainly seasonal, in his professional work. In some periods he is very active, in others almost totally lacking in initiative and in decision-making ability. This hampers him greatly and he is convinced that he has found his "limit" since this type of behavior allows him to contribute to the upkeep of the family but, according to him, it leaves him in a subaltern position compared to his wife's dominant social and economic importance. Furthermore his son, a pre-teen only child, is having difficulty at school and in socialising, problems that the specialist blames partly on the fact that the father is too strict with him. If the son does not do what B. wants there are violent scenes that end with B. saying "I can't do what I'd like to with you because your mother pays for your upkeep!...So I wash my hands of you". Family relations have obviously gone downhill due to this.

Before the consultation, on the advice of various specialists, B. had begun treatments with various anti-depressants but he did not benefit or perhaps – and probably – he did not continue with them in large enough doses or for long enough, as he could not stand the side effects or the idea that "a medicine is deciding for me!"
At the time of the first interviews, he appears eutimic. Rigid in his facial expression and posture, elegant in a sophisticated but slightly artificial way, like a mannequin. He is inflexible with himself and in his expectations of his son. He "worships" rationality and intelligence, makes a sharp division between good and bad, he underestimates and overestimates himself. He has serious problems with the control and manifestation of anger and aggressiveness. He is intelligent and sensitive in non-conflictual areas, functions well in social life and in various extra-family relations connected to work and friends and love, but fails constantly in the sphere of intimacy.
Firstborn of two sons, at the birth of his brother (when he was 3 or 4) he was taken away from home and entrusted to an uncle and aunt who lived in another city far from his parents' town, because his mother was not able to look after her very demanding and dependent husband and the two children at the same time. B. was "extremely happy" with his uncle and aunt, spoilt and pampered. He was brilliant at school, in sport and later in social life. But he always had a sense of dissatisfaction, of anger, of having to prove something, without knowing to whom. Very polite and formal, but with rare explosions of anger, seemingly for no reason, but essentially connected to feeling excluded.
B.'s father owned and ran a small factory. As years went by he became more and more isolated, angry and demanding; towards the end of his life, he would stay for long periods in the house or in his office at the nearby factory, immobile, inactive, showing only anger and hatred towards other people. He died after being judged "demented" due to this behavior. He left a financial situation which, despite the apparent wealth, was on the verge of collapse through debts and the lack of a market for what the factory produced. At the time B. was abroad finishing his post-graduate studies in order to establish himself in an autonomous position and also to get away from the troubled family atmosphere. His brother tried at first to solve the problems but soon gave up. B. returned home, bought out his brother, and then tried to restart his father's activity, but in the end he had to give up and stop the unprofitable production. He then began another activity of business services, which he was still doing at the time of the consultation.
His brother died unexpectedly of a cerebral haemorrhage. Since then B. has also taken care of his mother, who lives alone and with whom he is very thoughtful and also over submissive, however with perceived aggressiveness and protests that take the form of an excessive, even ridiculous,

obedience. There are times however when he is inflexible and demanding towards her, just as his father was.
He has been married for over 15 years to the mother of his son. He seems very attached to his wife but he cannot help being hostile and angry towards her when he thinks that she earns more than him and when she shows her attachment to her original family or when she cares lovingly for her son.

The patient's characteristics and the aspects of his history mentioned seem to point to the need for one session of psychoanalytical psychotherapy per week, with difficulties in the setting connected to B.'s frequent absences for his work.
From the outset, the relationship is marked by strong attachment and good cooperation on the patient's part in reconstructing the tendency to repeat, in present behavior, the experiences of the past. In the sessions B. talks about himself in current external life as if he were an external figure, "him" as it were, that he judges very harshly; the therapist is more compassionate, understanding him because he sees him as the product of a previous dramatic story. The therapist therefore represents a less sadistic object of the patient's Super ego. After a while, B. joins the therapist in this view, he cooperates and becomes a little less rigid and judgemental, and therefore livelier, more mobile and less guarded in participating in the relationship.
Almost a year after the start of the treatment, B. reports that he has no more work (his type of activity actually has seasonal peaks) and that, as he has so little to do, he has quite lost his initiative; a letter needing a reply has been lying on his desk for weeks, not ignored insofar as it is a sort of recrimination and monument to his inertia. At home too things are going badly, he is angry with his son who will not do as he is told, and with the boy's mother, who lets him get away with it. He feels jealous of this pair, excluded and envious, he cannot stand their good relationship or control his anger and his attacks on them, unless he resorts to isolation and sleep. He continues, in a series of very boring sessions, to present his impotence, his anger and his destructive might as in "whatever you all do (son, wife, collaborators, therapist), I'll always be stronger than you and I'll destroy you all".

Though seemingly containing some realistic, reasonable aspects, it seemed to the therapist that his ideas of ruin revealed a fractured view of reality, since he was not ruined despite all he said, even though with his behavior he did a great deal to make his convictions come true. In fact the therapy too was ruined; there was no "insight" but only intellectual understanding being derided.
His unexceptionable, regular behavior is a sort of derision of having to be good and normal. It is at this point that B. seems to understand a lot of things by himself, linking his behavior to his history but only to deride this understanding and without being able to see, apart from occasional glimpses, that it is precisely this way of deriding that is his current mode of repeating his history. In other words, the depression is now in transference. The work designed for the personality system in which reconstructions are also a means of repairing (it is the repetition of a history that does this) does not work when faced with an invasion of depression into his health and into his relationship with the therapist.

It seems inevitable at this stage to work on the personality system; there is material available and the connection with the problems underway is clear. On the other hand, their characteristics and their gravity brings into transference a sense of impotence in dealing with destructiveness. When it is possible to work on this, the patient seems to benefit from interpretations that bring him face to face with the anguish, the defences, the consequences of what can be seen, within the therapy, as a "negative therapeutic reaction". But the relief deriving from these moments, in the intervals between sessions makes his response angrier and more cruel at the loss of this therapeutic function that he is unable to provide for himself and for which he needs a therapist who is absent. All this seemed to repeat the problems triggered by the traumatic expulsion from his home at the time of his brother's birth and perhaps also by the previous relationship with a mother who was depressed because she felt incapable of responding to her spouse's demands as well. It also happened that, while in some respects the depression could be seen as being linked to past events that were being reproduced in therapy, the depression itself had such an effect on the relationship that it became a factor of stress, itself generating depression.
It was then decided, after more than a year of work, to advise him to start a pharmacological therapy. This decision entailed the therapist understanding that such a development had to be considered also as a transference and countertransference process of *enactment* (Purcell, 2008). "Enactment", according to the APA (2007) definition, means the putting into effect in the psychotherapeutic setting of a major life event that is not expressed verbally.

It was a “combined therapy” which can be integrated (prescribed by the same person) or separated (prescribed by two different people), an intervention that began during psychotherapy on the advice of the therapist who was also a psychiatrist, after previous rejections of other pharmacological treatments. The therapist felt that the patient was completely in his “care”; in recommending the medication he had done something to him and for him; he had decided that his anger in “the other six days” was so destructive that it prevented the psychotherapy from getting ahead. On the other hand, the therapist had become responsible for the envy and destructiveness of his depression but was also the focus of a certain “gratitude” for some small but important changes compared to previous similar periods. It then seemed necessary for the therapist to take full responsibility for his inability to heal the patient, so as not to repeat an event from the past, when the mother, incapable of looking after him, sent him to his uncle and aunt.
One way or another the medication would be introduced, due to emotional meanings, side-effects, and emotional meanings in the psychotherapeutic relationship. In fact if the drugs had been prescribed by an external figure, the psychotherapist might have had some reservations about them (the choice, the doses, the checks etc) and, above all, it might have ended up facilitating the process of contrast and division, both if the psychotherapist had appeared to be soft and pacific towards the pharmacotherapy and if he had seemed to react like a sterile windbag. This common artificial dilemma is often used as a defence by patients but also by health workers. In actual fact, there are some aspects that cannot easily be reconciled between the two types of therapy, like the different quality of the psychotherapeutic action, but the schematic juxtaposition mentioned above tends to place the patient in the difficult position of having to cut off one of the horns of the dilemma to have access to the other, but also to give up the possible advantages that could be obtained from one of the two therapies. In this specific case it is underlined that there was a clear continuity between personality traits and problems and the episode of depression. The personality showed many of the traits that the recent (2008) *Psychodynamic Diagnostic Manual* (PDM) attributes to the depressive personality. In particular it became evident that there had been a fracture in early relations, followed by self definition in a different context, characterised by a material and affective acceptance but “on condition that” the patient was active, capable, and brilliant. This resulted in a depression with simultaneous “anaclitic” aspects (feelings of solitude, abandonment, of being neglected) and “introjective” aspects (feelings of personal worthlessness, failure, guilt), to use the terminology used by Blatt (2006) and reused in the PDM. It therefore seemed to the psychotherapist that he should not facilitate the possible repetition, at least in the patient’s mental world, of this traumatic experience.

In the often paralysing dilemma between the patient’s need to relate and his fear of relating, the psychotherapist decided to take the active role in providing him with a therapeutic relationship, trusting that the work previously done would enable them to work on the terrifying aspects of relating. His anger about previous abandonment kept him either distant and starved in paralysing formal relationships, or frightened of the possibility of destroying the other person and/or himself, arising from his anger with himself if he was accepted only to be inevitably threatened with abandonment.

It was therefore decided to prescribe medication, considering their administration essentially, as in Eissler (1953), a *Parameter* in therapy, that is:
1. necessary to get over a stalemate;
2. dispensable when no longer necessary;
3. analysable in the relationship, trying not to “seize" material that cannot be analysed.

B. began the therapy with anti-depressants prescribed by the psychotherapist-psychiatrist. Despite the fears and expectations mentioned above, the sessions continued as before, except that at the end of the sessions, the medication was also discussed (the effects, side-effects, the doses, the progress of the therapy). The therapy done in this way did not involve any special new aspects in this period. Nor were any improvements reported. But after the expected latency of several weeks, the therapy started to show changes. The anger and destructiveness towards it lessened in the sense that they no longer appeared to have a paralysing effect. In schematic terms, the work done in the many sessions of this period can be summed up as follows: "You are trying to destroy your activity, your family relations, your relationship with me, your therapist, by behaving as your father did in his business, his family, and with you in particular. As you do this you feel hatred towards him, you are afraid and ashamed so hurting yourself is also a punishment for this and it paradoxically makes the “expulsion” from your home seem more acceptable to you, since you are “bad” you deserved it. You put the therapy to the test with this and you feel reassured by the fact that the therapy continues”. The attenuation of the hatred and destructiveness, that began after the medication started to be administered, made this kind of work possible on the depressive episodes. The latter can be attributed to the personality imbalances also linked to events external and internal

to the therapy, without however denying their biological and psychopathological identity and without dramatising as in “it’s either reactive, psychogenous and curable with psychotherapy, or it’s endogenous, with a biological cause and only curable with drugs”. On the other hand, the change came about after the introduction of the pharmacological treatment; it became possible for the patient to begin and continue the treatment placing the responsibility on the doctor. Never directly, but several dreams reported in the sessions let the therapist see and assess the presence of considerable persecutionary anxiety linked to the fact that the drugs were also poisons, the result of a therapist-parent retaliation. But this was narrated and discussed with the administrator of the substances and, by reassuring him on the level of reality, it was possible to make these anxieties less dramatic.

It is clear here that the integration of biological and psychological factors in taking the drug and accepting its effects is so close that it cannot be assessed separately, and it can be thought that ultimately it is a matter of two viewpoints, and two languages to talk about the same phenomenon. Once the episode had been got through, the psychotherapeutic work continued even after the medication was suspended, which happened after several months.

A similar need arose after about a year. This time the access to the drug was easier and the patient always retained a greater awareness of the communicative and relational significance of the symptoms. There was a re-accentuation of the depression when the date for the end of the psychotherapy was set and it was possible to get through this episode without resorting to drugs but by linking it to the imminent end of the therapeutic relationship.

As a whole the treatment was successful and a check up after several years showed the disappearance of episodes that could be clinically defined as major depression. It must however be pointed out that the therapist had the impression that the work following the first episode, while useful and profitable, became less creative than before, somehow more repetitive. It cannot be established whether everything that could be done with that technique had been achieved, apart from the reinforcement of the progress made, or whether the psychotherapist’s transformation into an administrator of drugs contributed to this limit. The therapist was convinced that his role had been shifted into the background at the end of the episode, to the relief of the patient who seemed to feel a certain embarrassment about his destructiveness during the depressive episode, and the desire, once it was over, to “turn his back on it”, ignoring it, *sealing over* as McGlashan & Keats (1993) say, suggesting the idea that in the treatment of acute breakdowns in cases of schizophrenia in remission, this solution is also linked to the use of supportive techniques instead of the expressive techniques of psychotherapy.

Discussion

The integration of psychotherapy and pharmacotherapy (in whatever form it may take) considerably relieves the body-mind problem.
Depression can be seen as a product of the mind and therefore described in terms of constructs like drives, defences, compromise formation, regression, self-esteem, object loss, and identification. Or it can be seen as a product of the brain, characterised by biological modifications of the psychoendocrinal functions and concentrations of neurotransmitters. Psychoanalysis emphasises concepts like object loss, the ideal of the Ego, aggressivity in the explanation of the phenomena and of the phenomenology of depressive states. On this point, a fundamental general reference is the triad identified by S. Freud in *Loss and Melancholy* (1915), i.e. object loss, narcissistic investment, identification. This is connected to present situations but starts in childhood, with the relation between disposition and events that Freud considered related to each other according to a pattern of “complementary series”. Brenner (1967) argued that the mental products of depression are due to associations between certain feelings and mnestic traces of conscious and unconscious depressive experiences that include object loss, loss of love and castration fear, the things called “childhood calamities”. On the other hand, starting from J. Bowlby, a part of the psychoanalytic world has stressed that attachment

problems can become “representations", possibly complex, as in “inner models of attachment" which, created in childhood based on a biological predisposition but also through “cultural” transmission (from mother to child), are active right through one’s life, though they can be modified, and they are fundamental in determining the modes of attachment and therefore also those of loss and of fear of loss. This stable basis, which constitutes a bridge between affective and cognitive aspects of mental life, cannot but have a biological foundation. Moreover, Mishkin, Ungerleider & Macko (1983), in order to explain the results of complex behavioral and neurophysiological studies in primates, presented models in which the emotions can influence perceptions, learning and re-evocations, based on neuroanatomical studies showing the presence in the central nervous system of structures linked to circuits that connect perceptions, memory and emotions. Kantor (1990) hypothesised that "childhood calamities" can leave biological traces of varying degrees of gravity, which are revealed later for instance when a loss takes place, as depressive affects or as actual depressive illnesses, supposing the original problem was part of the person’s biology as a quantitative or qualitative alteration in levels of neurotransmitters or as modifications of receptor sites in the membranes. These are attractive hypotheses, though obviously oversimplified, but they bring to mind the issue of the body-mind relationship and the fact that it is presented as a sort of “dichotomy”, for reasons that are essentially historical and cultural. The “psychic domain” cannot be separated from the “biological” one on which it is based (*We must remember… that all the psychological notions we are formulating little by little will one day be based on an organic substratum* Freud, 1914).

The Cartesian dualism of body – mind, impossible to eliminate at least in its linguistic expressions, and which must be seen not as being ontological but methodological (by necessity different methods must be used), *does not correspond to different essences but to different structures between psychic and non-psychic* (Green, 1991) or to different levels of organisation.

In the case in question, the childhood losses and the later adaptation of the personality are fundamental for an understanding of the case. But there is nothing in modern biology to stop us thinking that the same events, the affects connected to them, and their memory may have contributed to generating a biological propensity for depression, even though the factors underlying this propensity are not fully known. It can be argued that during periods of serious paralysing depression, from the psychotherapeutic viewpoint, the person finds himself before a wall, a sort of Freudian “rocky cliff” that cannot be scaled through the treatment of talking, but possibly by resorting to medication. It is often said (Kantor, 1990) that it is here that we find a limit in the psychoanalytical theory; it may be so, but it can also be supposed that it is a limit to the applicability of a therapeutic technique.
In B. it was possible to overcome the depressive episode the first time, using a combined, integrated therapy in which – not a frequent occurrence – the psychotherapist was the same person that administered the drugs, an unusual modality resorted to out of the fear, connected to the dynamics of the case, that a separation of the two figures would end up confirming the split and the separation of the significant figures that had taken care of him in the past. Moreover, though at a different level, every psychiatric therapy using drugs is a combined, integrated therapy handled by a single person since it is impossible, even if desired, to eliminate an inescapable psychotherapeutic component from any treatment, as Freud said (1904). In the case of psychiatry, the psychotherapeutic component is mainly of a subjective kind; in our case there was the attempt to make it possible to pursue an expressive therapy through the pharmacological treatment of a depressive episode which, seen through the eyes of psychotherapy, was an accentuation of the patient’s problems, with however a continuum of comprehensibility. The same picture, seen synchronically during an episode, could be evaluated from the point of view of the symptoms presented (apathy, motor and ideational inhibition, hypersomnia, loss of appetite) as an illness in itself.

The bio-psycho-social model seems to justify the situation well: the drug acts on the bio- system, psychotherapy on the psycho- system, and the difference is not inherent to the nature of the reality of the phenomenon but concerns different levels of the phenomenon itself. At the psycho- level there emerge properties that involve the bio- level, that is, cerebral activity, but the mental phenomena “like the emerging dynamic properties” are inseparably tied but “different from and more than” material cerebral processes, as Sperry (1968) wrote.
This represents, though many deny it, the question of body-mind dualism. As Goodman (1991) argued, it has been seen that the traditional dichotomy between the physical (organic) and the mental (functional) is a linguistic-conceptual issue rather than inherent to nature. All the events and processes involved in aetiology, pathogenesis, symptomatic manifestations and treatment of psychiatric disorders are biological and psychological at the same time. “Childhood calamities” may be such due to biological predisposition; it is reasonable to think that they have biological effects on the neurotransmitters, on receptor sites and so on. But as well as pharmacological therapy, also psychotherapy can have biological effects, probably finer and more specific than those relatively rough effects caused by the drugs currently available.

The difference may lie in the site where the effect is initially felt, on the one hand the neuromediators and, on the other, the systems of perception, construction of representations and symbolisations. Moreover it is often possible to see episodes of depression as moments of imbalance in a picture of post-traumatic stress disorder, which has become chronic in some aspects of the personality and reached crisis point due to later issues. Recently Marianne Leuzinger-Bohleber (2008), starting from observations obtained during the third analysis of a patient suffering from imbalance with strong overtones of depression and traumatised because in childhood she had been affected by a serious form of polio, puts forward the hypothesis that, for the purposes of a lasting structural change, it is indispensable to elaborate the traumatic experience in transference and in a historical biographical reconstruction of the trauma suffered. On the statistical level Horowitz, Wilner, Kaltreider & Alvarez (2009) found symptoms of depression in a high number of subjects affected by post traumatic stress disorder. Then matters get complicated and interwoven. Construing a coherent narrative in such a way as to avoid blame can reduce anger and trigger a positive “virtuous circel” of change involving personality structures and events. But in this process biological issues can be introduced, both due to changes in the background (for instance the borderline case of a reduction of mediators when the light was dimmed), and due to the "liberation” of mental contents, at first inhibited and controlled then revealed, having been made comparable by the improvements made. This worsening of symptoms could affect the psychotherapy, which may not be able to deal with the "vicious circles" that are established, causing a step backwards. By acting for instance on lowering destructive drives, drugs could re-start the process of change.

Naturally the issues referred to are always highly complex; the decisions of the primary therapist in a case are always linked to a dialogue (or to a block of dialogue), both at the intrapsychic and the interpersonal level.
The psychotherapist that prescribes an antidepressant must be able to carry out an Axis I diagnosis, understand the implication of such a diagnosis for the treatment, examine the alternative treatment options with the potential and/or already effective patients, being able to constantly monitor the symptoms of depression and give appropriate therapeutic recommendations during the treatment, conscious also of the fact that research into how a drug affects the therapeutic relationship is relatively recent and is being continually updated (Roose & Cabaniss, 2006).
The beneficial effects of a drug on the depressive symptomatology are expressed through two separate actions by the drug: the biological effect which reduces the symptoms of depression, and a psychological effect of relational significance (a parent continues to look after him and his anger at having been sent away, without destructive retaliation, but

actually understanding him and putting reparatory strategies into effect).The effect of the drug does not act however on symptoms separated from personality traits, as was long thought in psychiatry, at least until Klein (1977) dealt with hysteroid dysphoria using MAO inhibitors.

It is a highly complex path, rarely usable and always involving the risk of triggering a sort of fantasy of therapeutic omnipotence to defend oneself from the suffering, the feeling of impotence transmitted by patient's ingenuous dependence, the Freudian "hilflosigkeit" or the almost equivalent cognitive "helplessness". Great caution is therefore required in deciding to proceed with a treatment like the one described, which can only be carried out very rarely in peculiar conditions.
In view of the number and variety of factors involved, there are many possible errors. But perhaps a hypothetical perfect therapist, like a perfect parent, not only does not exist but if he existed, he would have catastrophic effects for instance on the sense of guilt and on the possibility of developing the reparatory capacities of the child-patient. Also the therapist who knows *a priori* what to do is certainly pathogenic. One can simplify "it is only a biological illness, drugs will cure it, obviously as well as an kind, understanding attitude " on the one hand; "psychoanalysis could cure it, but that is impossible for economic reasons, because he does not respect the setting or anything else and so let the psychiatrists deal with it!" (again identified, in the best cases, with kind pharmacotherapists).

This contrast, which may also contain elements of reality but that almost always has a dramatic exaggeration that makes it a lie with an obvious defensive significance, may at times, with difficulty and limitations as in the case described, be overcome through the twofold action of the professional figure; in the great majority of cases the intervention of two people is needed, one usually being a psychologist – psychotherapist and the other a psychiatrist who are used to working together, trust each other, and are capable of honest dialogue, which is often difficult but all the more necessary for being difficult. Introducing a third person into the psychodynamic psychotherapy setting, as was mentioned in the exposition of the case, as well as bringing the beneficial effects of the medication on the depressive symptomatology, can bring out interesting new fantasies and enactments both in the therapist and the patient. The former may have the hidden fear of being thought to be inadequate, while the latter may try to protect or to attack the therapist when he is relating to the psychopharmacologist (Roose & Cabaniss, 2006). It is therefore necessary for both to have the capacity to see how and to what degree the tensions, contrasts and any disagreements may be linked to the pathology and to the patient's defences. In other words, the two professionals must be accustomed to "team work". This is so both in public and private practice; they must not allow themselves to be paralysed by dilemmas but must see them as being linked to the patient and his pathology.
If one works in a public health facility – which cannot turn away anyone – or if one feels like a "doctor", obliged to help in suffering without necessarily being miracle healers, for instance, the contrasts described may end up containing a degree of sadism that may satisfy the masochism of the depressed patient, but that is isomorphic in its pathology, worsening, not changing, the situation.

Lopez & Zorzi-Meneguzzo (1988) wrote that to cure a depressed patient one needs an analyst and a therapeutic drug and, we can add, a family therapist, an expert in social work, etc. If these figures are available and the patient can use them, well and good! But it must be ensured that the best case does not prejudice a good outcome, that when this best-case scenario cannot be achieved, at least there is the attempt to get a psychologist-psychotherapist and a psychiatrist to collaborate, so as not to end up abandoning the patient and that is - essentially – making him worse, confirming that there is no way his anger and desperation can be accepted.

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