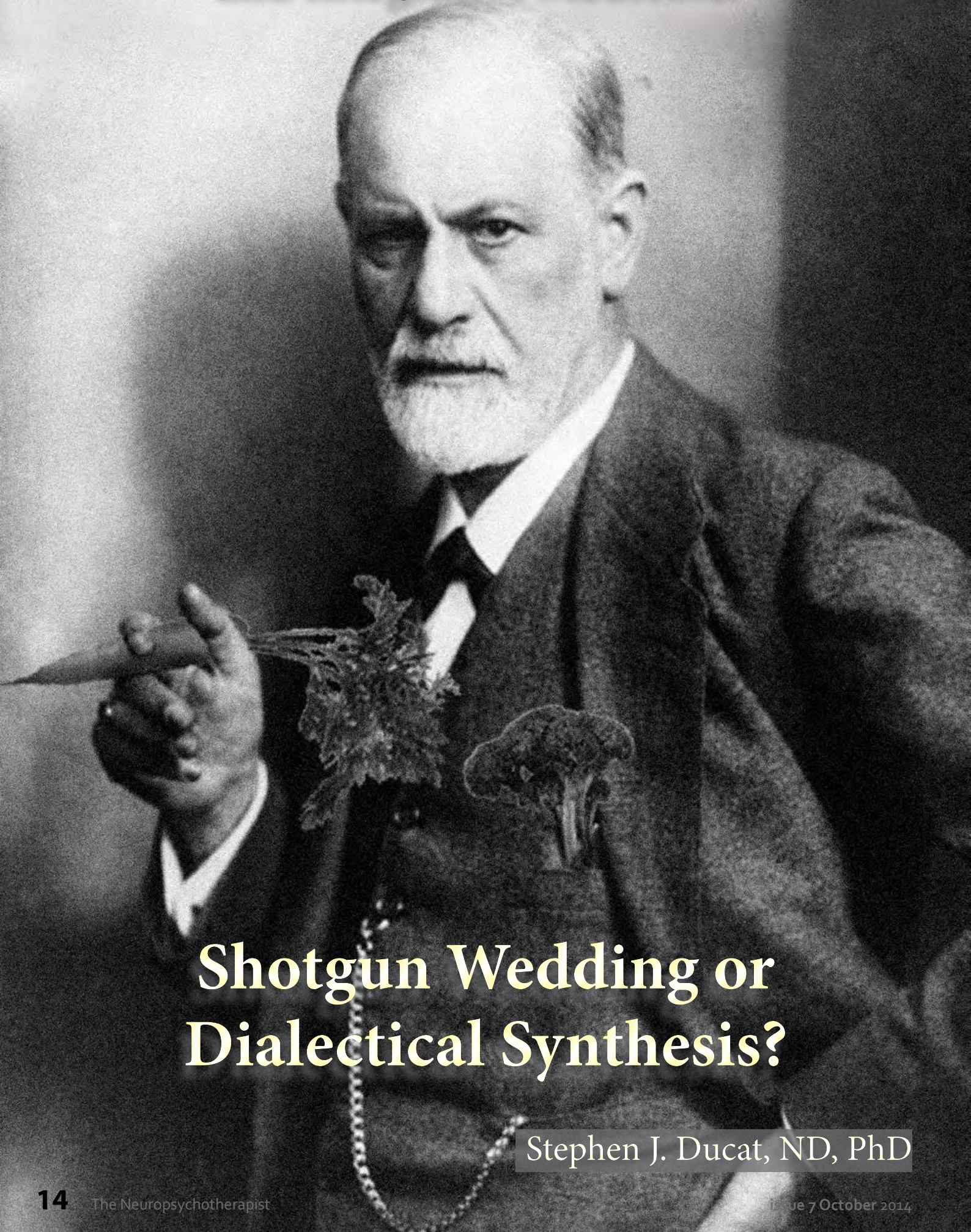


The Marriage of Psychoanalysis and Integrative Medicine:



Shotgun Wedding or Dialectical Synthesis?

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Bridging Two Worlds

The question posed in the title of this article matters to me because I am both a psychoanalytic psychologist and a naturopathic doctor. You could say I have a foot in each world—although it would be more accurate to say I have both feet in each world, along with two doctoral degrees, two licenses, two malpractice policies, and two communities of colleagues who have little understanding or knowledge of the other. And the gaps in that knowledge are sometimes filled with unexamined assumptions that eclipse the similarities and distort the differences.

On good days, my immersion in these two worlds feels integrated; but on the bad days it can feel like a tortuous bifurcation. While each discipline is steeped in paradigms that seek to understand and address *causes* (or meanings) and not just *symptoms* (or epiphenomena), it is not uncommon for colleagues in one world to view those in the other world as credulous adopters of an anecdote-driven, unscientific model, lacking efficacy. Sadly, in the history of each discipline there have been moments when these caricatures possessed more than a grain of truth.

Some analysts I have spoken to mistakenly assume that integrative or naturopathic doctors eschew scientific evidence and rely on fuzzy, romantic notions of what is natural to guide their assessments and interventions with patients; they are unaware that integrative doctors—like conventional physicians—are deeply grounded in the scientific literature and strive to base their work on the best evidence. Where naturopathic clinicians differ from their main-

stream colleagues, rather, is in the systems biology framework through which scientific data is rendered meaningful—something I'll unpack later in this paper.

Correspondingly, some integrative doctors tend to assume that psychoanalytic ideas are merely anachronistic relics of the Victorian “dark ages”, incompatible with contemporary neuroscience. Along similar lines, many of these clinicians uncritically accept the canard promulgated by a subset of academic psychologists—a canard that has filtered into popular culture—that only cognitive behavior therapy (CBT) has demonstrated efficacy and is thus the only so-called “evidence-based” therapy on the market.

Jonathan Schedler's meta-analytic study of the psychotherapy research literature persuasively debunks the myths that psychoanalytic treatment is any less efficacious than CBT, or that it lacks empirical support (Schedler, 2010). If anything, the evidence demonstrates the opposite. In fact, a series of studies by the late analyst and UC Berke-



ley psychotherapy researcher, Enrico Jones (with whom I was a research assistant), showed that when CBT therapists employ psychoanalytic interventions, such as attending to affect, working with and in the transference, and making links to the salient events and relationships of early life, they get better results (Jones & Pulos, 1993).

Clearly, therefore, to evaluate whether integrative medicine and the practice of psychoanalysis are compatible with one another, we have to move beyond the respective straw man critiques. For psychoanalytic clinicians this means having a deeper and more nuanced understanding of just what is meant by integration—after all, one person's integration can be another person's sloppy eclecticism. Defining this foundational term requires us to be clear on just what is being integrated in this new medical framework; but where we have to begin is by outlining the preexisting paradigm that integrative medicine is seeking to supersede—what Thomas Kuhn, the philosopher of science, would have referred to as “normal science” (Kuhn, 1962).

Paradigms in healthcare can exhibit their own versions of natural selection. Some of them survive because they seem more compelling than competing frameworks, with the result that they get reproduced in the public mind and passed on to succeeding generations. However, over the years, the limitations of the dominant medical model have become increasingly evident to clinicians and patients alike. Regardless of which end of the stethoscope we are connected to, more people now than ever before are viewing the conventional allopathic paradigm as an epistemological dinosaur. In the most extreme version of this worldview, disordered body parts, regions, and systems are imagined as disconnected entities treatable in isolation from the rest of the organism, with treatments that focus more often than not on downstream symptomatic *effects* to the exclusion of upstream *causes*.

With the partial exception of family practice doctors, conventional physicians are trained in unlinked silos of specialization; and once certified, specialty boards closely police disciplinary boundaries and sanction transgressors. At its worst, all of this eventuates in the tendency for patients to be reduced to the sum of their diagnostic codes.

Integrative medicine is a paradigm that has emerged in recent decades to challenge and address the limitations of this mainstream model. The most systemized, cogent, and developed version of this paradigm is functional medicine—a well-theorized, science-based body of concepts developed by the Institute of Functional Medicine (IFM). The IFM was founded in the 1980s by Dr. Jeffrey Bland, a nutritional biochemist and protégé of Linus Pauling, Dr. Joseph Pizzorno, founder of Bastyr College of Naturopathic Medicine, and Dr. David Jones, editor of the *Textbook of Functional Medicine* (Jones, 2010). In recent years their ideas have been incorporated into a number of forward-thinking conventional medical school curricula and residency programs across the United States, while the IFM's certification program is currently on its way to becoming an accredited postdoctoral medical fellowship. The theoretical, research, and clinical components of the Institute's work have added substantially more depth and substance to that vague adjective “integrative”.

To clarify my use of certain adjectives, for the remainder of this paper I will be using the terms *integrative*, *functional*, and *naturopathic* interchangeably to describe the type of systems-biology approach that might or might not be compatible with psychoanalysis. But it must be acknowledged that my usage here elides the many different connotations and denotations these descriptors carry in the larger world of alternative and complementary medical practice.

What is Integration?

The most succinct and useful definition of integration comes from psychodynamic psychiatrist and mindfulness teacher, Daniel Siegel (Siegel, 2010). From his perspective, integration is the linking of differentiated parts of a system. There are many domains of integration, including the body, the mind, social relationships, and health care; and when there is a failure of integration in any of these domains the result can be an imbalance—either in the direction of chaos (undifferentiated and disorganized states) or towards rigidity (unlinked and inflexible states).

Bodily integration refers to links between tissues, organs, structures, regions, and functions. This is called systems biology, the foundation of functional medicine. The metaphor of a spider's web might be clarifying here. Imagine the system of the body as a large web in which every node (where the threads cross), while distinct, is linked to every other node in the web. In this system each node represents a different aspect, or function, of our psychobiological being—one node might be the GI tract, another might be the stress response system,

and unstable, or the opposite—rigidly impervious to influence, and defended against its own multiplicity.

Unintegrated thoughts and beliefs can also limit our functioning. We can use projection to eclipse both our differences from and our similarities to others; and when it is unbearable to link parts of ourselves, we can find demonized others and use them as psychic toilets to evacuate that which we seek to disown. To manage the terrors of uncertainty, and banish complexity, the world offers a wide selection of fundamentalisms to soothe us: good and evil, black and white, sacred and profane are thus kept reassuringly unlinked.

Similarly, our emotions—perhaps through the activation of mirror neurons—can serve to link us to others (Ramachandran, 2011). Alternatively, by mobilizing disgust, for example, we can create effective barriers to connection. In fact, certain writers on the evolutionary biology of politics, like Avi Tushman, have argued that disgust is to a great extent an emotion that characterizes cultural conservatives (Tushman, 2013). This may be an affective marker of the refusal to link—be it to immigrants, the

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and another might be affect regulation. If you pull on one node in this metaphorical spider's web, there will be traction on every other node. So, it is hard to have a disordered part that is isolated from the rest of the system.

Mental integration includes links between our memories, thoughts, beliefs, emotions, components of our identity, and internal object- and self-representations. A breakdown of integration can manifest either as a failure to differentiate or a failure to link.

For example, there are ways that identity can be understood in terms of impaired integration. It can be dissociatively fragmented

poor, homosexuals, non-whites, or liberals.

The failure to integrate emotion can also lead to explosive disinhibition and impulsive acting out, on the one hand, or to disavowal and alexithymia on the other. Vital to mental integration is the role of neuroplasticity. When we practice what is difficult, or struggle in what Vygotsky (1978) called the proximal zone of development, we are issuing demands to our organism to adapt—to make the new, strange, not-me-but-desirable action or state a part of us. Deep and consistent practice—whether in psychoanalysis, physical exercise, or mindfulness meditation—facilitates the transformation of a state into a trait. Neurologically, the

integration of the new occurs through synaptogenesis (the creation of new synaptic connections), neurogenesis (the generation of new neurons), and myelinogenesis (the synthesis of new myelin, which facilitates communication within neural networks).

From the opposite direction, practicing self-reflection in an analytic dyad, as Peter Fonagy has shown, can build the muscles of mentalization (Fonagy & Bateman, 2006). This, in turn, can allow a pathology that was once a fixed trait, such as we see in personality disorders, to be transformed into a context-dependent state, one that becomes integrated into a large repertoire of available self-states. So, for the borderline patient, instead of every disappointment eliciting the molten fury of abandonment rage, the patient who has been helped

“Trojan Horse self,” which refers to the ways our deeply personal ambitions, dreams, and beliefs have been smuggled in by the larger social world, and passionately embraced and defended by us as our own. We are thus set up to perceive what is beneficial to the tribe as a whole in terms of individual self-interest.

Neuroimaging studies cited by Lieberman show that when a subject views his or her image in a mirror, the right ventrolateral prefrontal cortex is activated—the same brain region that lights up when individuals are engaged in tasks requiring self-restraint and compliance with social norms. Other studies have shown that when people are able to see their own reflection, they are more likely to engage in ethical behavior. There seems to be something about seeing

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to open up the potential space of reflective thought can make distinctions between the sorrows and object failures of the past and those of the present moment. When his or her proverbial ghosts are turned into ancestors, the patient is then capable of mobilizing righteous anger in the face of genuine betrayal or those times when he or she has been truly forsaken.

Social integration refers to the web of connection that links us with others, which can include romantic couples, extended families, communities, and larger societies. In a fundamental way this network of social connections *constitutes* who we are. Neuroscience has made important contributions to this decentered and context-dependent understanding of the self. Social psychologist and brain researcher, Matthew Lieberman (2013), has pointed out the ways in which the autonomous, individualistic sense of personhood that we humans (especially those raised in Western cultures) hold so dear is, to a great extent, an evolutionarily adaptive self-deception.

As tribal animals, our survival has always depended on congruence between our private aims and what others in our group value and reward. Lieberman calls this the

ourselves as others see us that reminds us of our place in the group.

Criminal activities might appear to be an exception to this view of the self, but even many seemingly antisocial behaviors could be understood as actions serving the interest of social connection. When the Mafia designates a member of its organization a “made man,” he has not earned that honor because he aggressively pursued his own ambitions, but because his criminal accomplishments have demonstrated his value and loyalty to the group. It is above all else an appellation that denotes *membership*. The same could be said of other criminal organizations, as well as terrorist groups.

In a slightly different way, powerful and predatory corporate CEOs are also driven by the promise of social rewards. What may look like ruthless individual efforts to obtain wealth, status and privilege, are essentially attempts to earn the powerfully gratifying acknowledgement that only other members of the tribe can offer. To have and be what others admire confers status and recognition, which, Lieberman points out, directly activate the brain’s social reward system, centered in the ventral striatum and septal area (Lieberman, 2013).

Pathologies in the domain of social integration, as in other domains, can manifest as failures to link or to differentiate, whereby we lead the life of a disconnected monad, being unable to give to, or take from another, or to have a sense of responsibility for others, or to experience kinship with those with whom we are interdependent.

Alternatively, we can be rigidly overly identified with our tribe, whereby individuation is feared as a slippery slope to banishment. In this view, having a differentiated self means relinquishing all connection—an existential crisis familiar to those who have survived cults, narcissistic parents, theocratic states, or totalitarian regimes. Viewed in cultural or ethnic terms, exogamy (marrying outside the clan) does not enrich one's group with the revitalizing tonic of otherness, but pollutes the tribe's blood with the poison of ethnic difference.

Functional Medicine

Functional medicine is the best and most developed framework for integration in health care. In this paradigm, an integrative model of the basic medical sciences (a systems view of how the body-mind functions) is married to an integrative approach to treatment. The aim of therapeutic intervention, especially in relation to chronic disease, is to assess and treat the causes. A clinically useful diagnosis requires that clinicians identify the antecedents, triggers, and mediators that eventuate in the "disease".

Another central precept of functional medicine is the notion of biochemical individuality. Twenty patients presenting with depression may be responding to twenty different psychosocial causes—variable combinations of etiological factors that could include early attachment trauma, loss, marital or other interpersonal discord, financial or professional setbacks, guilt over real or imagined transgressions, and an internal "pathological organization" (Rosen-

feld, 1971) that mandates the renunciation of joy or success.

Physiologically, the patient's depressive affective state might be co-determined by the effects of physical disabilities, genetic mutations, hormone imbalances, environmental toxin exposure, nutritional deficiencies, stealth infections, autoimmunity, protein mal-digestion, gluten sensitivity, or disturbances in gut microbial ecology, to name a few.

On the other hand, each of twenty people exposed to the same cause could end up with a different "disease" that could turn out to be bipolar disorder, anxiety, depression, schizophrenia, autism, dementia, rheumatoid arthritis, lupus, multiple sclerosis, diabetes, or irritable bowel syndrome. It is not surprising, then, that treating diagnostic codes produces such poor results, especially when working with patients suffering from complex chronic conditions.

None of the foregoing should be construed as suggesting that acute care or conventional symptom-suppressive (i.e., allopathic) treatment, whether surgical or pharmacological, has no place in an integrative or functional medicine model. Nor is there any reason that conventional practitioners cannot be part of an integrative treatment team, assuming they are collaborative and respectful, and that they value the larger aim of addressing causes. Sometimes what a patient needs is to have a tumor cut out, a fractured limb set, a raging infection treated with antibiotics, debilitating pain blunted with drugs, or a life-threatening manic or psychotic episode brought under control with psychopharmacology. While all functional medicine practitioners would make every effort to render these extreme last-resort interventions unnecessary, this is not always possible.

Mending the Mind/Body Split

Among the notions that might bedevil ef-





forts to integrate psychoanalytic and functional medicine approaches to treatment is the mind/body split—perhaps the most enduring of false dichotomies. For example, in January 2009, the Pentagon issued a decision that the Purple Heart (awarded to military personnel wounded or killed during service) would not be awarded to soldiers who acquired PTSD in battle because that disorder was not a physical injury. The generals seemed to be unaware of certain unassailable facts of the physical world: that the mind is a property of the brain, and that the brain is located in the body. In fact, the hippocampus, the neurological seat of our conscious history, and the amygdala, the primary brain locus of threat assessment, are among the worst physical casualties of traumatic stress; instead of a bullet to the head, the brains of soldiers who succumb to the psychic effects of battlefield trauma are flooded by a toxic tsunami of stress hormones. Hippocampal shrinkage impairs their memories, while shriveled and dysregulated amygdalae keep these warriors in a chronic state of vigilant terror. So, sadly, even though the military is guided by science (at least when it comes to killing people), it is still embedded in the Cartesian world of disembodied minds (Karl et al., 2006).

Perils exist at both ends of this split. In their efforts to treat ill bodies, integrative doctors embedded in the mind-body dichotomy can easily find themselves being complicit with their patients' somatizing defenses: by simply being inattentive to the realm of meaning they might enable patients who wish to avert their gaze from disturbing aspects of their inner worlds to

do so unchallenged. These doctors could readily forget that the body is as much an object of fantasy as it is a container of physiological processes. In addition, by offering formulations that only address abnormal lab values, it might be easier for patients to dismiss their emotions as simply epiphenomenal residues of aberrant biochemistry.

On the other hand, psychoanalytic clinicians can be at risk of collapsing into psychodynamic reductionism, which could encourage a mentalistic disembodiment, a sort of mind fetish that defends against somatic reality. Here the analyst may show keen interest in fantasies and associations but express little concern about the patient's diet of brain-destroying junk food, sedentary lifestyle, reports of multiple chronic medical symptoms, sleep deprivation, poorly supervised multi-drug regimen, persistent fatigue, and other seemingly banal aspects of their physical existence.

Any of these presumed non-psychic features of a patient's life outside the consulting room could have a profound bearing on his or her state of mind, including the symptoms that drove the patient to seek psychoanalytic treatment in the first place. Psychodynamic reductionism could thus lead to this material being heard and interpreted solely as series of symbolic narratives that have little significance outside of their transference meanings. In this context, to problematize any of these aspects of a patient's lifestyle might be regarded as a breach of neutrality, as well as a non-analytic descent into the concrete, yet the same analyst might be quick to advocate consultation with a psychopharmacologist when there is mental pain that can't be mitigated with words or metabolized through reverie. And while acute self-destructive acts might warrant a 911 call, chronic self-destructive behavior might evoke only the occasional interpretation.

Freud spoke of drives as unconscious mental representations of somatic states (Freud, 1915/1953). Analysts need to remember and take seriously the fact that mental life is shaped by a wide range of bodily activities—the by-products of digestion, the chemical messengers of our immune cells that account for the well-established

by-directional associations between mood disorders and inflammation, hormone fluctuations, and the cross-talk between the brain and gut bacteria. Of course, since mental life is a bodily activity, it clearly impacts all the aforementioned physiological processes in addition to being impacted by them.

The example of the gastrointestinal microbiome is particularly illustrative. The beat poet Richard Brautigan once said that humans were simply the means for water to get from one place to another. Echoing the social neuroscience work of Lieberman described above, the new field of psychobiotics—the use of probiotic micro-organisms to alter mental states—offers an equally humbling challenge to our sense of mo-

a symphony of subcortical brain structures that construct the neurological fiction of the masterful and sovereign self out of their need for co-ordination (Damasio, 2010). Along these lines, the work of the aforementioned psychobiotic researchers may leave us wondering if our brains are also doing the bidding of the micro-organisms that not only reside in us but also outnumber our own cells. Are we like rats who, once infected by the parasite *Toxoplasma gondii*, have an overpowering attraction to cat urine? In fact a growing body of research has found that humans infected with this organism are much more likely to engage in risky, and even suicidal actions, and to do so fearlessly (Zhang, 2012). Other scientists have conducted prospective studies demonstrating

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adic autonomy. It has been demonstrated experimentally that non-anxious animals have been made anxious by transplanting into them the intestinal bacteria from anxious animals; and, conversely, that the same anxious animals can be returned to a relaxed state by introducing certain probiotics (Collins, Kassam, & Bercik, 2013). Multiple human studies have also found that when fragments of gut bacteria leak into our blood stream through an impaired intestinal barrier, the resulting inflammatory response can induce depression (Maes, Kubera, & Leunis, 2008.).

In his provocative book *Infectious Behavior* (and no, it's not about projective identification), neurobiologist Paul Patterson has catalogued multiple examples of microbe-induced psychopathology, from autism to schizophrenia to depression (Patterson, 2011). These bug-brain interactions can be viewed as reminders of what we as analysts already know in other ways—the mind and the self it generates are not sovereign, but always embedded in and constituted by relationships. As it turns out, that includes relationships with microbial species.

Neuroscientist Antonio Damasio describes how the conscious self is like a conductor, but one that is brought into being by

that individuals exposed to a live flu virus through immunization have a sudden and sometimes uncharacteristic desire to socialize (Reiber et al., 2010). As this route of exposure does not produce symptoms in most people, the increased urge to be around others cannot be attributed solely to illness-induced comfort-seeking.

Molecular Psychodynamics

While the mind may be the experiential and relational interface of the brain—the Platonic mental shadows emanating from the neuro-cave—it also has properties of agency. As Norman Doidge has pointed out, it is a means the brain uses to change itself (Doidge, 2007). This may take the form of engaging in psychoanalysis, eating healthfully, or practicing meditation, each of which is a neuroplastic and epigenetic intervention. In other words, they are experiences that alter the structure and synaptic connections of our brains, and influence the phenotypic expression of our genes.

In a review of psychotherapy research in *Psychiatric Times*, Professor Hasse Karlsson at the University of Helsinki places one more nail in the coffin of the mind/brain split. The

study discussed by Karlsson provides further evidence that psychotherapy is as much a physiological intervention as are medications, nutritional treatments, and botanical therapies. Perhaps most significant, indeed ironic, is the finding of a Finnish study indicating that psychodynamic psychotherapy produces increased serotonin receptor density in the brain, whereas Fluoxetine does not. Karlsson speculates that this increased physiological change from talk therapy over that produced by medication may account for the observation of other researchers that the relapse rate for major depressive

apolipoprotein E epsilon 4 allele (APOE* epsilon 4) significantly increases one's risk for developing Alzheimer's dementia. In an 18-month prospective trial with 100 elderly men and women with a family history of this disease, sedentary subjects who were carriers of the gene experienced a 3% loss in hippocampal volume over the course of the study. However, those who possessed this gene and engaged in regular moderate exercise lost no hippocampal volume, and their brains were indistinguishable from the control subjects, that is, those who were not carriers of the risk allele (Smith et al, 2014).

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disorder is lower in patients treated by psychotherapy alone than in those receiving antidepressants alone (Karlsson, 2011).

One way of understanding the power of psychotherapeutic intervention is to consider its impact as an epigenetic influence. Two types of effects determine the function of our neurocircuitry: genetic (the mostly unalterable predisposition endowed by heredity) and epigenetic (the environmental factors that can lead to changes in gene expression—either upregulating or downregulating the products of genes, like neurotransmitters). We may inherit cassettes of genes (rarely are single genes determinative on their own) that could theoretically increase our risk for multiple diseases, from Alzheimer's to depression to cancer. But, depending on multiple lifestyle factors like diet and exercise, those genes may never be expressed. The power of the latter (i.e., physical activity) to determine phenotypic expression is particularly remarkable.

Among psychotherapists, it is a generally valid article of faith that it is not possible to run from one's mental problems. One of the stark exceptions to that truism is Alzheimer's disease. It is well known that possessing the

Some pathology-inducing epigenetic influences, like environmental toxicants, starvation, and psychic trauma, can not only lead to disease expression in those exposed but may also produce adult-onset disorders in children and grandchildren who may never have had any direct exposure themselves. For example, the literature is replete with profoundly troubling findings that have emerged from animal models of transgenerational toxicity-induced disease, especially as it pertains to neuropsychiatric conditions. In one of these studies, prenatal exposure to BPA, a ubiquitous endocrine disrupting environmental chemical, affects social behavior and brain gene expression three generations into the future (Singh, 2012).

Stephen Stahl, one of the most eminent authorities on psychopharmacology, has made a surprising but cogent argument: psychotherapy can be regarded as an “epigenetic drug” that is no less effective in altering brain circuitry than is medication (Stahl, 2012). For example, he points out that the amygdala can remember, perhaps permanently, what has terrified you (e.g., the traumas of childhood) and what has been rewarding (e.g., addictive sub-

stances or behaviors). The synaptic connections formed by these experiences do not go away. Nevertheless, psychotherapy—through its capacity to generate new experiences and thus produce epigenetic changes in the chemistry of neurocircuitry—can create new synaptic connections that eclipse or inhibit the earlier ones. Of course, for Stahl, this is ideally achieved through the synergistic epigenetic effects that come with the combination of drugs and psychotherapy. From my perspective, however, the often quite modest efficacy and not so modest adverse effects of these drugs make them an adjunctive modality of last resort. It is better to assess upstream causes and employ epigenetic modifiers of function that enhance health, rather than add new, drug-induced symptoms. These health-optimizing modifiers can include diet, herbs, exercise, and meditation, as well as psychotherapy and psychoanalysis. (However, it must be acknowledged that sometimes non-psychiatric drugs, like antibiotics, can be an upstream treatment, not just symptom-suppressive, such as in microbe-mediated neuropsychiatric conditions.)

When all that I have outlined above concerning the mutual constituting relationship between mental life and other physiological processes becomes widely disseminated in the culture at large, the brain/mind split will go the way of flat earth theory. At the same time, it will become increasingly evident that psychoanalysts and their patients are engaged in more than a hermeneutic enterprise, and that they are also agents of neuroplasticity and epigenetic metamorphosis.

So—by making an impactful interpretation, we are delivering a biological intervention. Nevertheless, mixing psychoanalytic with other more obviously physiological approaches can still be perilous. And I will address some of these perils shortly.

Psychopharmacology, Functional Medicine, and Psychoanalysis

The limitations of psychiatric drugs notwithstanding, there are important questions being asked in the debates on the use of psychopharmacology in psychoanalytic treatment (Mintz & Belnap, 2006). These

discussions come the closest to addressing the opportunities and pitfalls of trying to join other biological approaches like integrative medicine to psychoanalysis.

It might be useful to begin this exploration by creating a large category that we can call “extra-analytic interventions”. This rubric would include drug prescribing, also referral to a prescriber or any other practitioner, or hospitalization. In addition, this category would subsume the ordering and interpretation of lab tests, as well as giving nutritional or any other lifestyle recommendations that impact psychological functioning such as those pertaining to sleep, exercise, or meditation.

I would argue that to be engaged in extra-analytic interventions does not imply being non-analytic. We all know that nothing happens between analyst and analysand that is not subject to conscious and unconscious meaning-making by both parties—one of the first things we learn as budding clinicians is that transference and countertransference feelings and enactments can get organized around the most seemingly trivial and pragmatic exchanges between the members of the analytic dyad. Extra-analytic interventions, therefore, should be subject to the same self-reflection, inquiry, and active curiosity as any other aspect of our work.

Rachael was a 57-year-old woman with history of early neglect and abuse who had also suffered from a 30-year history of treatment-resistant depression—by which I mean refractory to psychopharmacology and, to a certain extent, psychotherapy. In some respects, Rachael had two histories.





There was the compelling overarching story of her trauma and its disabling emotional *sequelae*. Yet there was also the story of her disavowed strengths, agency, and resilience, which she had periodically manifested in spite of that trauma, or perhaps in response to it.

She had just completed two and a half years on the couch as an analytic control case, during which she had made great strides, both intra-psychically and interpersonally. In several ways we were beginning a new phase in the treatment. Still on the couch, we had reduced our frequency to twice a week. In addition, Rachael had expressed an interest in using me as a doctor as well as an analyst. Aware of my naturopathic medical work, and still suffering from depression (though significantly reduced since the beginning of our work), she wanted to hear my thoughts on the possible upstream physiological contributors to her lingering depression, as well as certain other chronic medical conditions, which she suspected were all linked together.

After exploring Rachael's hopes, fears, and fantasies associated with shifting her use of me—and after coming to terms with my own anxieties about changing the frame—I agreed to move forward with her request. I said that the first step, before arranging laboratory testing for her, would be to review any recently completed lab results that had been ordered by her primary care doctor. She said she'd have them for me at our following appointment.

At the beginning of the next session, while still on the couch, she started to reach behind for an envelope that she said contained recent lab tests, as if to hand it to me—but she lifted her arm up only a few inches, not enough for me to actually grasp the envelope. I noted what appeared to be hesitation. She said, "I feel like I'm about to expose myself to you, to be naked in ways that I've never been with you, showing you not my skin but my organs. It's like that

old kid science toy, the Invisible Woman, the transparent plastic doll whose insides you can see from the outside."

"And what might be revealed if I were to look into you?" I asked.

"You'll see even more than you have already how broken and bad I am," she replied.

For the remainder of that session we revisited in a new way what had been an enduring theme in our work—Rachael's conflict over her desperate longing to be seen, and her terror that visibility would reveal her repellent inner rot and badness, and leave her more alone than ever. It wasn't until our next session that I actually looked at her lab results, and we began the process of assessing and treating the biological substrates of her depression, all the while continuing to listen with a "third ear" to the meanings she made of this new component of our work.

Often the objection made to extra-analytic interventions is that they are departures from the non-directive approach that can be so facilitative of the analytic process. But as I noted above, even a referral to a psychopharmacologist is a directive action—and not a trivial one. When you make such a referral, especially if it is unsolicited—be it for the patient's depression, suicidality, mania, hallucinations, paralyzing anxiety, or cognitive disorganization—you are saying, "Your psychic pain is of such magnitude that talking and listening may be insufficient." If you are a non-prescriber, you are also saying, "If you're going to get well, you need more than what I can offer. Our work must be supplemented by another therapeutic relationship." Moreover, when patients are in danger and resist your recommendations, you might, heaven forbid, even exhort them to comply.

Don't get me wrong here!—I'm not exhorting analysts to exhort. My point is that most clinicians are not able to avoid the ten-

sion between the necessary degree of directiveness a particular patient might require and the non-directive neutrality that can be so mutative in psychoanalytic work.

But neither am I saying that any directive extra-analytic intervention is fine or unproblematic, or can be capriciously introduced. It must be preceded by the same self-examination about one's motivations and countertransference, the same rigorous attention to the patient's psychology and likely response, and the same considerations of timing and phrasing as would precede any interpretation.

Now I want to direct my focus to two extra-analytic interventions that would be more commonly understood as non-psychotherapeutic biological interventions, medication management, and integrative or functional medicine practices. There are continuities and discontinuities between these biological approaches, and also ways they can each facilitate and impede psychoanalytic work.

The ways that medication can function as a psychic object is a good illustration of its Janus-faced role. On the one hand, a drug, if it alleviates symptoms, may be construed as a more reliable object than the analyst, and one that is under the omnipotent control of

of soothing are joined in the drug/doctor object. For patients with significant attachment trauma, it might render the dependency on the analyst, and the periods of separation, bearable enough to do the work without profound dysregulation.

Functional medicine interventions, whether diet modifications, supplements, hormones, antimicrobials, or exercise prescriptions, could also be experienced as psychic objects. As with psychiatric medication, following these protocols could support fantasies of the analyst's redundancy, reducing him or her to a technical consultant and enabling an evasion of transference wishes and fears.

Unlike drugs, functional medicine approaches treat causes, not just symptoms. They do not lead to the restricted range of affect so common to psychiatric medication. Instead, they address the causal impediments to optimal self-regulation, strive to increase resilience in the face of intense feeling, and aim to remove the physiological obstacles to full vitality. Of course, not all patients welcome vitality. It can be experienced as a terrifying challenge to internal bad objects and pathological organizations—but at least that challenge opens up the possibility of fruitful work, which might

Functional medicine interventions, whether diet modifications, supplements, hormones, antimicrobials, or exercise prescriptions, could also be experienced as psychic objects

the patient. This could enable the patient to resist the transference or, more precisely, to evade any direct experience of it—both because disturbing affects toward the analyst are blunted and because the analyst can be construed as superfluous. Anxiety over the perils of dependency, or sexual or aggressive feelings, can be preempted. More broadly, medication can become a fetishistic or totemic substitute for real but unreliable and uncontrollable human relationships.

On the other hand, medication may be experienced as a transitional object (Winnicott, 1953), a link between the “me” and “not-me” aspects of the analyst who is being ingested physically and mentally. The symbolic and psychophysiological aspects

be foreclosed by affect-deadening medications.

As with drug treatment, functional medicine protocols similarly are recommendations by the analyst that the patient needs to implement on his or her own, outside the consulting room; and, since (like meds) some form of ingestion is involved, there may also be a fantasy of incorporating the analyst. Thus—as with psychiatric drugs—these practices can lend themselves to use as transitional objects.

A risk of any biological treatment, psychopharmacological or naturopathic, is that the patient could view his or her emotions as simply markers of an illness rather than as experiential guideposts to meaning. Of

course, as analysts, we want to diminish unnecessary suffering to the greatest extent possible. Nevertheless, it can be a significant impediment to analytic work when psychic pain is broadly pathologized. Under those circumstances, pain might lose its vital signal function—telling us about our internal and external worlds and enabling us to exercise judgment and act accordingly. Along these lines, a hazard unique to drug prescribing is that, because of its blunting effect, it can sometimes lead to an atrophy of the patient's capacity for affect tolerance and emo-

analytic treatments concerns whether one practitioner should implement both kinds of treatment, or whether they should be divided between two clinicians (Andrus, 2010). The latter is often referred to as a split treatment. For the sake of clarity, I use the words *doctor* to denote the biological "treater" and *analyst* to denote the psychotherapeutic clinician. In my view, the arguments on both sides of the debate about splitting treatment apply equally to the two biological treatments under discussion—that is, medication management and functional

There are many reasons for favoring a split treatment. Perhaps most importantly, it enables the analyst to avoid the difficult and sometimes awkward shifts in the frame.

tional self-regulation. In this respect, it is not unlike the use that is often made of alcohol and illicit drugs.

Patients receiving functional medicine treatment may find themselves pathologizing psychic pain in different ways. Notions of treating causes and not symptoms—a noble and appropriate aim—can evoke wishful expectations of cure, not palliation, which is not always achievable. With some patients, this can foster omnipotent fantasies of perfection and a pain-free life. This can be rendered doubly problematic when it coincides with our own countertransferential therapeutic ambition for our patients. We may, for example, have the fantasy that by curing the patient we might be able repair our own irreparable losses, make whole what in us has been torn asunder, or shore up our own flagging sense of professional competence.

In patients with narcissistic character structures, fantasies of a biological path to perfection can make it even more difficult to help them come to terms with the limitations of reality, and their own fallibility, along with necessary and even fruitful suffering. Biologizing psychic pain—even if there is a significant physiological component—can facilitate a kind of splitting, whereby a patient's badness is imagined as illness, so that once treated, only the good is left.

Another major area of contention regarding the integration of biological and psycho-

medicine practices.

There are many reasons for favoring a split treatment. Perhaps most importantly, it enables the analyst to avoid the difficult and sometimes awkward shifts in the frame. In other words, the analyst does not have to pose concrete questions, make direct recommendations, focus so intensely on the body, make eye contact, derive biological meaning from extra-analytic patient data such as lab findings, or assume responsibility for more than the impact of their words. In addition, the clinician engaged solely in analysis can sidestep all the psychic perils and transference/counter-transference tumult described above that can be associated with combining biological interventions with analytic treatment.

On the other hand, dividing the treatment between two clinicians can introduce other kinds of splitting, where either the doctor or the analyst can be idealized or devalued. If the doctor's medicine produces positive results, for example, he or she can be seen as the potent one, while the analyst may be viewed as providing little but ineffectual psychobabble. If the doctor's medicine yields no benefit—or worse, produces adverse reactions—he or she can become a peddler of quack nostrums, or even a malevolent purveyor of poison. This might contrast with the analyst, whose good interpretive milk might be experienced as

nourishing.

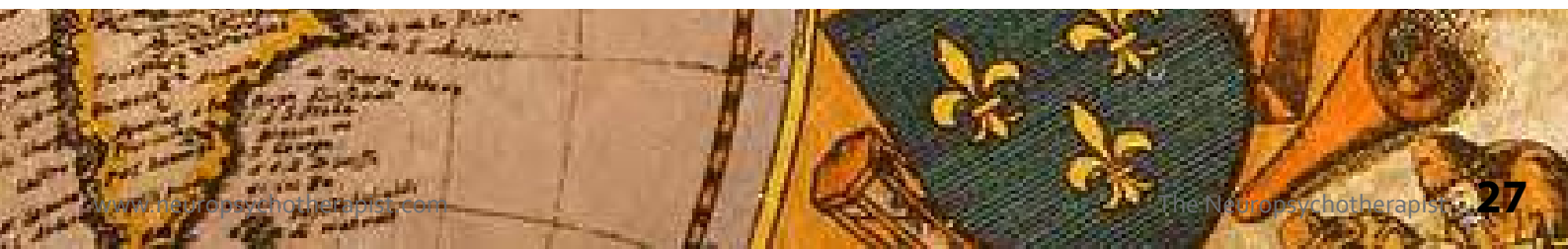
Alternatively, the direct advice of the doctor may be seen as support, whereas the analyst's neutrality might be viewed as withholding; or it may appear that the doctor, who intervenes in the real bodily world of the patient, offers a promise of enduring analgesia, if not bliss. This is unlike the analyst, who might seem to be either taken up with psychic ephemera or determined to elicit mental suffering. Seen through this lens, the analyst is simply inviting the patient to while away the hours doing the free-association fandango, often rewarding expressions of pain with the flattering gift of analytic curiosity. And yet the analyst offers no soothing balm! Moreover, he or she even has the nerve to suggest that there might be value in feeling one's pain. Obviously, I've touched on only a few of the possible configurations that splitting might assume in a divided treatment.

Another downside to out-sourcing the biological component of treatment is that the transference/countertransference dynamics evoked in response to the doctor are largely unavailable to analysis, at least not in a direct way. They can only enter the work—as any other report about the patient's outside life might—as a secondhand narrative. This becomes especially problematic if the person functioning as the doctor is not very psychologically minded, or believes that he or she is somehow operating in a transference-free zone, or is simply unwilling to take up the transference in a short med-check visit.

This brings to mind Oscar, whose story will conclude this paper. Oscar was a 61-year-old Hispanic-American man in psychoanalytic treatment for depression whose medication prescribed by a local psychiatrist had ceased to provide even the modest benefit it had initially afforded. I gingerly raised the possibility of referring him to an integrative doctor in the area who might be able to do a comprehensive laboratory work-up on him,

potentially to identify physiological causes (triggers and mediators) that might guide more effective treatment of his depression. This was a period when I was just starting to integrate naturopathic approaches to neuropsychiatric conditions into my practice and at that point I was only doing split treatments, being the doctor in some cases and the analyst in others, not daring to join these two roles with the same patient. Splitting the treatment was also Oscar's strongly stated wish. As he put it, "I don't want to hate you if it doesn't work." I assented to his preference, while on some level knowing I was being complicit with a split already in place, and potentially enabling one in the future. Perhaps I was also acting out my countertransference reluctance to jeopardize his fragile idealization of me. A little bit of history may illuminate what later transpired.

Oscar was the only child of a largely loveless marriage. His father was an alcoholic and frequently absent due to his various affairs and long-haul trucking business. When at home, he was mostly disengaged from the family, preferring to spend time in the local bar. Oscar's mother was loving but profoundly lonely. While she provided well for him, she increasingly looked to her son for emotional sustenance. When Oscar's father died in his early adolescence, the mother's psychological dependence on her son grew significantly. She frequently reminded him that he needed to be successful in life so that he could adequately provide for her later; and, when he did leave home, she made it clear that detailed reports of his life provided a vitally needed psychic transfusion—he had to live a rich life so that she might feed off the dividends. Feeling parasitized, he developed the fine art of being unavailable for her phone calls. When he did have contact with her, he worked hard to keep their conversations vague and brief. Attenuating his relationship with his mother came at the cost of considerable guilt and consequent resentment. When that resent-



ment would occasionally leak out, however mildly, his mother would collapse into an inconsolable puddle of self-hating sorrow. This of course reminded him of his primary job in life, which was to shore her up.

As Oscar grew into adulthood, he developed a powerful attraction to consensual sadomasochistic affairs in which he would nearly always seek to be the bottom. The draw of this erotic preference was not pain but passivity—to be done to, rather than to have to do for others. More broadly, he saw himself as lazy, as not wanting to do what has to be done. Oscar constantly assailed himself for lacking ambition, in spite of achieving an advanced degree in his field.

Even before Oscar showed up for his first consultation with the doctor I referred him to, he was annoyed because of the long history form he had to complete. When he had to get a number of lab tests, his annoyance passed into profound irritation; and then, after getting the doctor's report of findings and treatment recommendations, his irritation mutated into fury. The doctor did not limit her approach to the provision of certain botanical and nutritional supplements, as he had expected, but actually required him to do a number of things for himself, such as change his diet in certain ways and begin an exercise program. He was also angry with me for making the referral—so much for my fantasy of remaining the good object—and he precipitously terminated his work with the consulting doctor.

However, in the analysis fruitful understandings did follow from this episode, principally related to his unfulfilled fantasies of being a medical bottom and his maternal transference to the doctor. But because neither the doctor (who was not psychologically trained) nor the patient could take up the transference meanings arising from this consultation, a potentially helpful medical treatment was abruptly aborted.

There is a more sanguine epilogue to this story. After two more years of analytic work, the patient felt ready to use me as a doctor as well as an analyst. In other words, he could tolerate the possibility of being disappointed in me, should the treatment fail to yield satisfying results; and, finally, he felt ready to exercise some agency in his health

care. Just as significant—I felt ready to take on the challenges of also being the doctor and not send him elsewhere. This meant, in part, having a greater tolerance for being the bad object in the event that this new aspect of the work failed to help him.

After much exploration of the possible meanings and impacts that this change might usher in, and with some trepidation on both our parts, I ordered some lab tests on him. The results identified certain nutrient deficiencies and genetic variations that had profound implications for his dopamine function, and hence on the biological component of his depressive tendencies. A treatment plan was implemented, to which he responded with a full resolution of his symptoms, and with no side effects. This has not meant that he does not still struggle with sadness, occasional despair, an attraction to passivity, and conflicts over his own agency. However, he can at least do analytic work on these concerns without the additional lead weight of a low-dopamine depression.

In this paper I have endeavored to sketch out the possibilities and perils of joining integrative or naturopathic medicine to the practice of psychoanalysis, and to identify the ways in which this synthesis is both similar and dissimilar to the problematics of combining psychopharmacology with psychoanalytic work. In the beginning I described how my professional identity contains the DNA of both the naturopathic and psychoanalytic traditions. My hope is that as I continue to explore this integration, each of these traditions will continue to claim me as a descendant.

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