

PSYCHODYNAMICS AND PSYCHOPHARMACOTHERAPY IN THE TREATMENT OF DIFFICULT PATIENTS WITH PERSONALITY AND EATING DISORDERS

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SUMMARY

The complex inter-relationship between external and internal reality, a source of interest and controversy in psychiatry, has come to the foreground more prominently in the context of more integrative understanding of psychopharmacotherapy. This paper discusses the meaning and clinical applications of the psychodynamic related to psychopharmacotherapy for difficult personality and eating disorders patients. The one of the psychodynamic explanations for patients' being difficult is related to their perceived lack of mentalizing (reflective) capacities. Lack of mentalizing capacity implies disturbed view of psychopharmacotherapy. Therapeutic relationship and optimal alliance offers the frame for acceptance of psychiatric drugs as positive and useful for personality and eating disorder patients. Mentalization and intersubjectivity theories have direct implications for clinical practice, and that the notion of the third is particularly useful in understanding what happens in the patient-doctor relationship.

Key words: psychodynamics – psychopharmacotherapy – mentalization – intersubjectivity - psychoanalytic psychotherapy - difficult patient - personality disorder - eating disorder

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INTRODUCTION

The complex inter-relationship between external and internal reality, a source of interest and controversy in psychiatry, has come to the foreground more prominently in the context of more integrative understanding of psychopharmacotherapy. In this paper, focus is on the relationship between current psychodynamic theories (especially collaboration of the patient and the psychiatrist) and psychopharmacotherapy for difficult personality and eating disorders patients. Mentalization and intersubjectivity theories have direct implications for clinical practice, and that the notion of the third is particularly useful in understanding what happens in the patient-doctor relationship.

Personality and eating disorder patients as “difficult patients”

The “difficult patient” is a well known term in psychiatric practice. It is underrepresented and not simply defined in research reports and scientific databases. The adjective difficult often refers to the lack of cooperation between patient and psychiatrist: the patient seeks help and care but without optimal compliance. Difficult patients are hard to characterize as a one group, they are better described in the form of their characteristics. Medical-psychiatric dichotomy “between ill and not ill” is very pronounced in diagnostic categories of personality and eating disorders, especially from the social-moral point of view. New knowledge's has lead to more holistic treatment in psychiatry (Jakovljević 2008). Koekkoek et al. (2006) analyzed the studies refer to four dimensions of difficult behaviors: withdrawn and hard to reach, demanding and claiming,

attention seeking and manipulating, and aggressive and dangerous. The first category is found mostly among patients with psychotic disorders, the second and third mostly among those with personality disorders, and the fourth appears with both diagnostic groups. Our experience regarding psychopharmacotherapy in the treatment of difficult personality and eating disorders patients show that psychodynamic is crucial for understanding individual cases. In accordance to earlier study (Robbins et al. 1988), we also have found a high correlation between difficult patients, the number of hospital admissions, and inpatient days, which indicated a higher prevalence of difficult patients among inpatients (in relation to outpatients). Among difficult personality and eating disorder patients we observed significant problems regarding dependency needs. These patients, who exhibit emptiness, denying, depression, or self-destructive behaviors, all have problems in tolerating a normal dependency. In qualitative interviews with nurses, a clear difference was found between “good” and “difficult” dependent patients (Strandberg et al., 2003). Good patients were described as reasonable and thankful; difficult patients were described as unreasonable, selfish, and not able to appreciate the value of given care. Psychodynamic view is that difficult patients have pronounced character pathology. Many of difficult patients have a so-called borderline personality organization (Kernberg 1967), which would explain why so many difficult patients have a highly ambivalent relationship with psychiatrist and also non-compliance in the sense of psychopharmacotherapy. The difficult patient discovered through the literature (Koekkoek et al. 2006) is either not motivated or ambivalently motivated for treatment and has a disease that does not neatly fit into one diagnostic category, which also does

not gradually improve, patient is often unpleasant to be with, may sometimes be out of sight, sometimes blames the mental health system for taking too little or too much care before. In series of book published by Medicinska naklada (Narcissistic Personality Disorder: Diagnostic Contribution 2013; Eating Disorders: From Understanding to Treatment 2013; From Violence to Dialogue 2014; Personality Disorders: Real People, Real problems 2015), our team emphasized the link between psychopathology of personality with different and difficult personality and eating disorders.

Mentalizing and difficult patients

Mentalizing implicitly and explicitly is the basis of self-awareness and a sense of identity (Allen 2003, Holmes 2010). Mentalizing in treatment of patients with personality and eating disorders is based on a growing body of evidence that points to mentalizing as the key to resilience (the ability to adapt successfully to adversity, challenges, and stress). By promoting resilience, mentalizing promotes coping with vulnerabilities, frequently presented in these patients. Patients with personality disorders have a problems in mentalizing in the face of trauma and negative stress resulting in increasing of symptoms. Psychodynamic view is that symptoms are on the surface, outside and inside is vulnerability regarding immature personality. Mentalisation deficit can be secondary to the abnormal functioning of the attachment system because of developmentally early dysfunctions of the attachment system frequently in combination with later traumatic experiences in an attachment context. The hyper-responsiveness of the attachment system has negative impact upon mentalizing. Fragile mentalizing leads to return of earlier psychological modes of function – teleological, psychic equivalence and pretend mode (Bateman & Fonagy 2004):

- Psychic equivalence mode includes mind-world isomorphism (mental reality = outer reality, internal has power of external). Self-related negative cognitions are too real.
- Pretend mode means that there is no bridge between inner and outer reality. Mental world has decoupled from external reality and linked with emptiness, meaninglessness and dissociation in the wake of trauma. Lack of reality of internal experience permits self-mutilation.
- Teleological stance are formulated in terms restricted to the physical world. A focus on understanding actions in terms of their physical as opposed to mental outcomes. Only action that has physical impact is felt to be able to alter mental state in both self and other. Physical acts as a self-harm are frequently presented.

Reflection lies at the core of doctor-patient relationship. Therefore, deficit in optimal mentalization and incapability to reflect will easily turn the patient into a

difficult patient. The one of the psychodynamic explanation for patients' being difficult is related to their perceived lack of mentalizing (reflective) capacities. In our earlier papers (Marčinko 2011, Marčinko et al. 2013) we described that patients with personality disorders suffered from constitutional vulnerability. Failure to mentalize are in relationship to rigid and repetitive patterns of interaction. Rigid interactions and more of projective defence mechanisms interfere with mentalizing. According to investigations many of personality and eating disorders patients have impaired activation and adjustment of the fight or flight system (a brain system that activates the psychological and neuro-hormonal responses triggered by signals of danger), also leads to the inhibition of mentalizing. Internal stressors (reflection of disturbed sense of self) are also inhibitors of optimal mentalizing. The inhibition of mentalizing leads to inappropriate responses that impair interpersonal relationships and perpetuate maladaptive cycles of experience and coping. Therapeutic alliance regarding psychotherapy offers more realistic view oneself and others from a fresh perspective. Patients with personality disorder have a lack a optimal sense of self, at a deeper level they do not know who they are, or how they impact on others. Capacity to form intimate relationships is disturbed and in relationship with psychiatrist the issue is similar. Lack of mentalizing capacity implies disturbed view of psychopharmacotherapy. Therapeutic relationship and optimal alliance offers the frame for acceptance of psychiatric drugs as positive and useful for personality and eating disorder patients.

Link between family therapy and psychopharmacotherapy

Family therapy for personality and eating disorder may be a helpful addition to traditional BPD treatment plan which include individual therapy, group therapy and psychopharmacotherapy. Family therapy is usually suggested when either the symptoms are negatively impacting the functioning of the family, or when problems in the family may be making the symptoms worse. Sometimes these two problems interact - the symptoms impair family functioning, and poor family functioning makes the symptoms worse. This kind of vicious cycle can be addressed in family therapy. Results of our study (Marčinko & Bilić 2010) show that female patients suffering from borderline personality disorder and eating disorder with positive suicidal history treated by family therapy had significant improvement in harm avoidance, self-directedness, depression and suicidality compared to group without family therapy. Family dynamic also changed in these patients. Results of investigation emphasized the role of family therapy in reducing self destructive patterns of behavior in female patients suffering from borderline personality disorder and eating disorder. The treatment of patients with personality and eating disorders is today more hopeful than it was in the past. During the past

period, psychiatrists have become overly dependent on pharmacological treatments, neglecting psychotherapies even when they are evidence-based. There are much scientific evidence that support association between psychoanalytic therapies and neuroscientific data regarding psychopharmacotherapy (Rudan et al. 2008, Marčinko et al. 2011). Family therapy provides a space in which family members can begin to inquire into their own and each other's processes of mentalization. Family therapist is someone who provides the opportunity for both implicit and explicit mentalization. Our clinical work and experience at Unit for Personality, Personality and Eating Disorders (Department of Psychiatry, Clinical Hospital Center Zagreb) emphasized the protective role of family therapy for young patients with eating and personality disorders. Result of family therapy lead to better understanding of symptom dynamic and should be helpful in creative psychopharmacotherapy.

Interpersonal factors and countertransference with difficult patients

Koekkoek et al. (2006), analyzed papers of some authors and emphasized that it is not the patient but the therapeutic relationship that is difficult, thus taking the blame off the patient and situating problems in an interpersonal context. Traditional concepts of transference and countertransference are often used in this context of difficult personality and eating disorders, yet in a broader sense than in classic psychoanalytic theory (Marčinko et al. 2008). These patients are very sensitive on external factors which lead to greater impact of external reality to internal psychic world. Emotional struggles are significantly presented while working with difficult patients. Projective identification can be understood as a means of coping with negative emotions for difficult personality and eating disorders patients. Psychiatric findings support the view that it is important for therapists working with difficult patients to reflect upon their own countertransference feelings. In psychoanalytic theories, people fitting the criteria of borderline personality organization tend to use psychological defences such as splitting and projective identification (Gabbard & Wilkinson 2000), and these produce complex and chaotic reactions in the therapeutic setting. Prominent among counter transference responses are guilt feelings, rescue fantasies, transgressions of professional boundaries, rage and hatred, helplessness, worthlessness, anxiety and even terror (Gabbard & Wilkinson 2000). Consultation can be of extraordinary value in such cases, but only if the therapist selects a consultant who can see the situation from a new perspective and who is allowed to share that perspective with the consultee (Gabbard 2003). There is significant relationship between treatment outcome and the different countertransference feelings among the therapists. Therapists' negative countertransference feelings are correlated with, and probably contribute to, a poor

treatment outcome. It is important to recognize that countertransference can be effective in understanding the emotional intensity of the difficult person's internal world and could be important in the context of psychopharmacotherapy. The difficult patient is considered a specialist in behaving differently (strongly influenced by splitting) with various team members, resulting in mutual disagreement but some authors reported that multidisciplinary teamwork with difficult patients is highly necessary (Main 1989, Maltzberger 1995). Such teamwork leads to less trouble and fewer mistakes, because countertransference issues can be shared and different professionals may experience distinctive feelings of countertransference (Menninger 1998). Team analysis should be useful when patient manipulate with medication. Difficult behaviors are differently interpreted as deliberate on wards with a psychodynamic orientation than on wards with a psychopharmacological orientation (Lancee & Gallop 1995).

Clinical implication of psychodynamic for psychopharmacotherapy in difficult personality and eating disorders patients

Psychiatrist prescribing psychopharmacotherapy needs to recognize differences between inner and outer realities of difficult patients. Mentalizing is the basis of optimal and sustaining relationships. A key notion underlying the concept of mentalizing and psychopharmacotherapy is providing secure base inside therapeutic relationship and alliance as a basis for improved mentalizing in patients with history of disturbed mentalizing with important persons. Secure attachment (good therapeutic relationship) leads to the improvement of mentalizing which lead to better compliance regarding psychopharmacotherapy.

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