安田女子大学紀要　49，43-50　2021.

Further Consideration on the Role of Clinical Psychiatry in Nurturing Autonomy of Patients with Personality Pathologies

Masayo Uji

パーソナリティ病理を有する患者の自律を育むことにおける精神科臨床の役割についてのさらなる検討

宇治　雅代

Department of Nursing,
Faculty of Nursing, Yasuda Women's University

Abstract

In a clinical setting, the importance of obtaining informed consent has been emphasized. However, for patients with personality pathologies, due to their damaged ability of decision-making, it seems extremely difficult to either give consent or dissent, despite their intact intelligence. This article, based on the author's previous writings[1),2)] which described those patients in detail, depicts a deepened understanding concerning their difficulties of making decisions, or exercising autonomy, related to early life events using a few scholars' theories. Clinical strategies which help those patients exercise autonomy are also proposed as well as a few issues remaining to be explored in future research.

Keywords: personality pathologies, autonomy, traumatization, release of true self, integration of personality

Introduction

In contemporary clinical psychiatry, the principle of respecting autonomy has been considered as one of the pivotal pillars along with the three other principles: beneficence, non-maleficence, and justice[3)]. Therefore, respecting an autonomous decision made by an individual who is regarded as competent has been imperative. Uji[1)] argues that clinicians should go beyond just adhering to the procedure of assessing each patient's competency in order to evaluate the rationality of respecting their autonomy, but more importantly should nurture the autonomy of patients with personality pathologies. In order to do this, the clinicians have to establish and share the hypotheses regarding developmental processes of these patients' pathologies by exploring each patient's life history in detail.

In this article, the author argues the meaning and developmental mechanism of the patients' symptomatic manifestations and behavioral patterns related to early life events, using a few theories. The author proposes clinical strategies to be adopted in order to recover these patients' well-being, including the ability of decision-making. A few additional issues which remain to be explored in the research realm are also proposed.

Origin of impaired ability of exercising autonomy and alienation of self

Uji[1),2)] introduces some patients who had difficulties in expressing their own feelings and opinions due to rejection anxiety caused by the inability to trust others. Some patients were not even able to recognize their own feelings, in particular anger and envy, and also what they actually wanted to do. The origin of these personality characteristics was identified in their very early mother-infant relationship. They had not been provided with an environment under which they were allowed to express their "true self[4)]". Their "true self[4)]", or "integrated psychological core from which a person acts authentically, with true volition[5)]" had been repressed or denied. They had learned that it was correct not to express their actual needs, feelings, and ideas. Instead, they had come to learn communicating with others using "false self[4)] " in any situation. They were always preoccupied with how other people evaluated them, reading into the people's feelings. Their motivation for any activities, i.e. studying and/or working, was extrinsic. They had not been able to experience the "feelings of excitement, accomplishment and personal satisfaction[5)]" in any activity they had engaged in because the "self–the author from which authenticity emanates[5)]" was alienated.

They lacked experience of their "primary passive love[6)]", a psychological need to be loved, being fulfilled. Their need of being loved was usually hidden, despite its unrealistic increase. They behaved as if they did not have such need. They blended into their environment by passively submitting to others, and/or acting. On the other hand, their unrealistic need of being loved drove them to actions with preconscious intention of manipulating others, which brought about a variety of maladjustments.

As to parenting during the early stage of life, Winnicott discusses the crucial role of the mother in fulfilling the need for her baby's intrinsic motivation, focusing on the early mother-infant relationship. He argues the mother's role in nurturing her infant's creativity and spontaneity, which are necessities for playing, using the term "primary creativity[7)]" and "environment-mother[8)]". The environment-mother is characterized by the empathetic attitude and its coherence.

The patients introduced by Uji[1),2)], according to their perception, unfortunately had not experienced the empathetic mother described by Winnicott. Their images of their mother were extremely indifferent, neglectful, or controlling, or a combination of two or more of these, characterized by an inconsistent parenting style due to the mother's convenience. As a result, they were not able to trust others, and were always afraid of being abandoned or betrayed, in particular, if they expressed their opinions or needs to be loved. Their innate need for the

"intrinsic motivation" i.e. "the process of doing an activity for its own sake, of doing an activity for the reward that is inherent in the activity itself[5]", which is very close to Winnicott's idea of "playing[7]", was damaged, due to the lack of reciprocal trust with their mother.

The concept of "trauma-related disorders[9]"

These patients seemed to adapt to their environment by a "false self[4]" on the surface. On the other hand, they actually had a wide range of symptomatic and behavioral problems, such as denial, depersonalization, anesthesia, enhanced sensations, dissociation, amnesia, hypersensitivity within interpersonal relationships, substance addiction, self-destructive and anorectic/bulimic behaviors. These symptoms can be well understood by applying Van der Hart, Nijenhuis, & Steele's model that endorses "the spectrum of trauma-related disorders[9]" concept, consisting of the two key elements explained below.

The first is based on the "structural dissociation of the personality[9]" caused by traumatization. They premise two personality parts: "Apparently Normal Part of the Personality (ANP)" which helps an individual with traumatization adapt to the environment at surface level, and Emotional Part of the Personality (EP) which was activated at the time of traumatization[9]. As previously described, Uji's subject patients behaved as if they did not need to be loved. This behavior is definitely the conduct by ANP when applying Van der Hart et al.'s terminology. According to Van der Hart et al., patients with traumatization have "phobias of attachment and of attachment loss[9]" due to the inappropriate parenting they received in their early lives. Uji's subject patients' intense desire for attachment, which was identified through their behaviors, was eliminated from their consciousness, but continuously remained, even in a bloated form, in their preconscious or unconscious levels. This desire can be regarded as one of the EPs according to Van der Hart et al.'s terminology. The main reason the patients had to cut off this desire from the ANP is as follows: According to what they believed, it was that desire that caused their past traumatic experiences, i.e. if there had been no desire, there would have been no betrayal.

In addition to the desire for attachment, some patients completely denied negative emotions towards their mother, such as resentment and grudge, inseparable from traumatizing events, because they believed that their aggression towards the mother would cause further rejection. These emotions also seemed to constitute another EP, isolated from the other parts of personality.

Van der Hart et al. write that children are more susceptible to negative mental events compared to adults, resulting in more severe dissociation of personality. This is because children's immature mental efficacy and psychobiological development do not enable them to integrate negative mental events[9]. This is applicable to all of Uji's subject patients. They had chronic and continuous traumatic events in their relationship with parents, especially with their mother, resulting in complicated division of personality.

The second essential element of Van der Hart et al.'s model is the classification of

symptomatic problems into four categories, i.e. negative-positive and psychoform-somatoform symptoms. These symptoms are developed by either ANP or EP, or both[9]. The above exemplified symptomatic and behavioral manifestations are understood as intrusion of EP into ANP, EP into EP, and ANP into ANP, or loss of a variety of mental functions[9]. In the example previously described the intense desire for being loved as well as the negative feelings do not keep silent by complying to ANP, but it claims its existence by converting itself into impulsive, sometimes even self-destructive behaviors, or other symptomatic manifestations. Compared to the personality of an individual with no dissociation, ANP functions poorly, because it consumes a considerable level of energy, preventing the invasion of EP by adopting various defenses, symptoms, and problematic actions. Their ego is extremely vulnerable, leading to "loss of mental skills[9]" exemplified as one of the negative psychoform symptoms by Van der Hart et al. This includes their impaired ability of making decisions and exercising autonomy. As a result, it tends to invite further traumatic events, i.e., further personality division.

Strategies of *nurturing autonomy*

As described above, although the patients with personality pathologies seemingly adapt to their environment, their personality is not integrated and therefore their ego functions poorly. Patients usually relate to others with "false self[4]" or ANP[9], products of a defense mechanism to avoid risk of being rejected. Their true self is usually concealed[9], because releasing it would be dangerous as far as they are concerned. Integrating the self as a whole requires intensive intervention. I would like to mention two essential points that clinicians should pay attention to when giving intensive psychotherapy.

First, it is essential to have a structured therapeutic frame to help these patients feel secure. It is crucial for the therapist to protect the patient from any violation of the therapeutic structure. They are very sensitive to the therapist's inconsistency within the therapeutic frame structure including minor changes of the scheduled date or time, and would perceive it as betrayal by the therapist. This can sometimes be a product of the therapist's acting-out caused by countertransference. When this happens, the patient clearly re-experiences an object-relationship from the past. In order to avoid this tragedy, the therapist requires self-searching ability. Only under this structured therapeutic frame can the intensive psychotherapeutic intervention be rewarding.

Second, the therapist should be an "autonomy-supportive listener[5]" for his/her patient to get insight about themselves. Deci emphasizes the importance of "autonomy support[5]" by describing a clinical case of a woman who was diagnosed with anorexia nervosa. The psychodynamic approach in which Deci's colleague Ryan empathetically listened to her feelings and thoughts behind her behaviors brought about her insight on herself including her relationships with her parents. The previous therapist's strategy to modify the woman's undesirable eating habits to desirable eating habits through control was the re-experience of her traumatic experiences with her parents. Ryan's approach supplied the "autonomy

supportive listener[5]". His supporting care would correspond to the "treatment phase one[9]" proposed by Van der Hart et al. It would give the patient the ability to look at his/her feelings, behaviors, and actions more objectively. When this clinician's autonomy supporting care is internalized, and subsequently integrated into the patients' personality, the patients' ability to enjoy exercising autonomy will be nurtured. Above all, they would be able to have a sense of self-regulation and responsibility for their own decisions and actions. The repetition of this experience would then bring about beneficial effects on their extra-therapeutic relationships.

The goal which each patient has to achieve is to leave behind beliefs, attitudes and behavioral patterns possessed since early life, and acquire a new beliefs and more adaptive behavioral patterns. For this to be realized, of particular importance is that the therapist not negate the patient's cognition and behaviors which he/she is familiar with. The therapist must empathize with the patient that these were strategies for them to live through past harsh environments.

Issues in future research and clinical practice

Finally, a few issues which remain to be explored should be mentioned. First, many previous studies have examined the relationship between perceived parenting during childhood and each mental disorder later in life such as borderline personality disorder (BPD)[10], process and substance addiction[11),12], eating disorder[13], and dissociative identity disorder (DID)[14]. However, empirical studies –based on Van der Hart et al.[9] theory that mental disorders such as post-traumatic stress disorder (PTSD), DID, BPD, and, in some cases, somatoform disorder are the products of structural dissociation of personality caused by traumatization, constituting "the spectrum of trauma-related disorders"–are scarce. The lack of ability in exercising autonomy and making decisions described by Uji[1] also can be derived from this pathology (the structural dissociation of personality). To develop a diagnostic system explaining these mental disorders in a unitary way, empirical studies identifying personality pathology they share are expected. In addition, whether other mental disorders–such as eating disorder and substance abuse disorder–often comorbid with a trauma-related disorder also derive from the dissociation of personality should be clarified empirically. Furthermore, it should be proven whether the above enumerated each mental disorder is solely developed by the dissociation of personality following traumatic events, or there are other factors which influence its development.

Second, it is important for clinicians not to be occupied with each particular symptom caused by traumatization. Therapeutic interventions which focus just on the manifest symptoms, such as cognitive behavioral therapy for controlling the eating behavior of eating disorder patients, and anxiolytic drug medication for alleviating intense anxiety expressed by somatoform disorder patients, would not be effective. The clinicians should consider whether there is a dissociation of personality behind the manifest symptoms. When personality dissociation is identified, they have to empathetically help patients explore why it became

necessary for them to continue to have splitting personalities in the context of past and current negative mental events.

In this article, I included some commentaries on ***nurturing autonomy***[1] by applying the ideas of self-determination theory and structural dissociation of personality. Uji's idea nurturing autonomy[1] indicates the supporting care and intervention which facilitate personality integration and help the patient discover their "true self".

Acknowledgement

The author would like to express deep gratitude to Masahisa Nishizono, Emeritus Professor of Fukuoka University, who supervised the author in treating her patients introduced in this article.

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〔Received September 17, 2020〕

Contributor：Professor Morihisa FUNATSU（Department of Psychology）