

MENTALIZATION AND PSYCHOPHARMACOTHERAPY IN PATIENTS WITH PERSONALITY AND EATING DISORDERS

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SUMMARY

Contemporary psychiatry pays more and more attention to the patient's capacity regarding acceptance of psychiatric drugs. Understanding the basis of our treatment's effectiveness becomes more challenging. To understand psychiatric treatment psychiatrists must pay full attention to mentalizing and the conditions under which this basic human capacity becomes impaired especially in those suffering from personality and eating disorders. This paper discusses the meaning and clinical applications of the mentalizing related to psychopharmacotherapy for personality and eating disorders patients, including suicidality.

Key words: psychopharmacotherapy – mentalization - personality disorder - eating disorder – suicidality - psychoanalytic psychotherapy

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Introduction

Contemporary psychiatry pays more and more attention to the patient's capacity regarding acceptance of psychiatric drugs. Understanding the basis of our treatment's effectiveness becomes more challenging. The capacity to distinguish between the internal and the external reality, concrete meanings and metaphorical ones, is viewed by contemporary psychotherapists as one of the most important features of the mind. If the patient lacks the capacity to symbolize, one of the psychiatrist's main tasks is to develop it. Peter Fonagy has developed these issues and formulated the concept of reflective function related to mentalization. To understand psychiatric treatment psychiatrists must pay full attention to mentalizing and the conditions under which this basic human capacity becomes impaired especially in those suffering from personality and eating disorders. This paper discusses the meaning and clinical applications of the mentalizing related to psychopharmacotherapy for personality and eating disorders patients.

Definition

Bateman and Fonagy (2004) define mentalization as 'the mental process by which an individual implicitly and explicitly interprets the actions of himself and others as meaningful on the basis of intentional mental states such as personal desires, needs, feelings, beliefs and reasons'. British psychiatrist and psychoanalytic therapist Jeremy Holmes (2005) summarizing the phenomenology of mentalizing: (a) involves the capacity to empathize, i.e. to be able to put oneself in another's shoes, (b) encompasses the ability to see and evaluate oneself and one's feelings from the outside, (c) denotes a capacity to differentiate feelings about reality from reality itself, (d) is a graded rather than all-or-nothing phenomenon, (e) is related to arousal, and (f) is enhanced by the presence of a secure soothing partner or other intimate.

Four distinct roots of mentalizing

Mentalizing has four distinct roots: cognitive psychology; psychoanalytic Object Relations theory (especially the work of Bion); francophone psychoanalysis; and attachment theory-influenced developmental psychopathology.

Mentalizing and therapeutic alliance

It is of great challenge to understand how medications work or to understand how psychotherapy helps. Investigators have been studying these interventions for decades. In today psychiatry, we combine these standard interventions with many other therapies. Mental health professionals emphasize the "biopsychosocial" model of treatment, believing that we must integrate the biological, psychological, and social domains as well as the spiritual domain. This theoretical approach is frequently lacking in clinical practice regarding reductionism in psychiatry. Educating patients about our understanding of therapeutic process can make an important contribution to establishing a therapeutic alliance and collaboration between patient and doctor. Optimal therapeutic alliance is crucial to a positive outcome in therapy. Collaboration is based on a sense of working together toward shared understanding and goals. One of the main concepts regarding alliance is mentalization.

Suicidality as a deficit of mentalization

We can look on suicidal process from many angles. New knowledge's has lead to more holistic treatment in psychiatry (Jakovljević 2008). Our team has studying suicidality last years, mainly in the field of neurobiology and psychotherapy (Marčinko et al. 2002-2011). One of the main factors in suicidal prevention is area of intersubjectivity (between patient and psychiatrist/psychotherapist). The important part of intersubjectivity

is mentalization. Patients with personality and eating disorders are frequently suicidal. Suicidality is a complex process which implies a deficit of mentalization. Mentalization is disrupted in individuals with borderline personality organization and suicidal potential, who tend to misinterpret others' motives. Regarding failure of mentalization, psychopharmacotherapy for these patients should be created on the intersubjective deeply experiences, not only to reduce presented symptoms on the surface. Jeremy Holmes (2010) emphasizes the role of attachment theory and promotes the secure base in the context of optimal therapy for severely regressed and suicidal patients. Previous paper in this journal emphasized the role of intersubjectivity in the context of psychopharmacologic response regarding suicidal borderline patients (Marčinko 2011). A number of questioners addressed the issue of a psychiatrist's technique when faced with the different levels of communication of the suicidal patients.

Mentalizing and borderline personality disorders

Patients with personality disorders suffered from constitutional vulnerability. Mentalization 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 2002).

- 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.

Mentalizing and psychopharmacotherapy for personality and eating disorders patients

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. Symptoms are on the surface, outside and inside is vulnerability regarding immature personality. Failure to mentalize are in relationship to rigid and repetitive patterns of interaction. Rigid interactions and more of projective defence mechanisms interfere with mentalizing. Our brain is designed for mentalizing but it is also designed to turn off mentalizing in response to danger. 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 neurohormonal 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 borderline 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. Psychiatrist should be empathic and with containing abilities when talking about psychopharmacotherapy with personality disorder patients. One of the key points in creative psychopharmacotherapy is achievement of full therapeutic relationship. Parents' attachment status and reflective function (RF) predicted secure attachment in the child. Bion sees the capacity for 'thinking' as dependent on the mother's (and by implication the analyst's) capacity for 'reverie', i.e. to love her infant in a way that enables her to tolerate his projections, to contain them, metabolize them, and return them for reintrojection when the moment is right (Holmes 2005). Potential borderline personality disorder sufferers may have had developmental experiences which compromise RF. This suggests that RF and the capacity for mentalizing is lacked in the context of psychopharmacotherapy. Patients have created new relationship (with psychiatrist) but mentalization is previously damaged. Accumulating studies suggest that extreme forms of insecure attachment, especially disorganized attachment, compromise mentalizing abilities in later life (Grossmann et al. 2005). This in turn may act as a vulnerability factor for the emergence of borderline

personality disorder (Holmes 2003). Therapeutic relationship and optimal alliance offers the frame for acceptance of psychiatric drugs as positive and useful for personality and eating disorder patients.

Clinical implication of improved mentalizing for psychopharmacotherapy in personality and eating disorders patients

The terms mentalization and mentalizing have recently emerged in the psychoanalytic and psychiatric literature. Clinical implications include the treatment of people suffering from psychiatric disorders especially personality and eating disorders. Psychiatrist prescribing psychopharmacotherapy needs to recognize differences between inner and outer realities of these patients. A key notion underlying the concept of mentalizing and psychopharmacotherapy is providing secure base inside therapeutic relationship and alliance. It is 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, and, reciprocally, that the capacity for mentalizing is a marker of secure attachment. Optimal mentalizing implies taking psychiatric drugs according recommendations.

Key points

- Mentalizing implicitly and explicitly is the basis of self-awareness and a sense of identity.
- Mentalizing is the basis of optimal and sustaining relationships.
- Relationships involve a meeting of minds – mentalizing is language.
- Optimal and sustained therapeutic alliance need to improve mentalizing in a secure attachment relationship.

Acknowledgements: None.

Conflict of interest : None to declare.

References

1. Allen JG, Bleiberg E & Haslam-Hopwood T: *Mentalizing as a Compass for Treatment. The Menninger Clinic, Houston TX, 2003.*
2. Bateman A & Fonagy P: *Psychotherapy for Borderline Personality Disorder. Mentalization-based Treatment. Oxford University Press, Oxford, 2004.*
3. Fonagy P, Gergely G, Jurist E & Target M: *Affect regulation, mentalization and the development of the self. Other Press, New York, 2002.*
4. Giannoni M & Corradi M: *How the mind understands other minds: cognitive psychology, attachment and reflective function. Journal of Analytical Psychology 2006; 51: 271–284.*
5. Grossmann KE, Grossmann K & Waters E: *Attachment from Infancy to Adulthood: The Major Longitudinal Studies. Guilford Press, New York, 2005.*
6. Holmes J: *Borderline personality disorder and the search for meaning: an attachment perspective. Australian and New Zealand Journal of Psychiatry 2003; 37:524–32.*
7. Holmes J: *Notes on mentalizing – old hat, or new wine? British Journal of Psychotherapy 2005; 22: 179-198.*
8. Holmes J: *Exploring in Security. Towards an attachment-informed psychoanalytic psychotherapy. Routledge, London, 2010.*
9. Jakovljević M: *Transdisciplinary holistic integrative psychiatry - a wishful thinking or reality? Psychiatr Danub 2008; 20:341-8.*
10. Marčinko D, Begić D, Filipčić I, Martinac M, Marčinko A & Medjedović V: *Neurobiological parameters of suicidality. Socijalna psihijatrija 2002; 30:79-84.*
11. Marčinko D, Marčinko A, Kudumija M, Martinac M, Kudlek-Mikulčić S & Karlović D: *Suicide in Schizophrenia: Risk Factors, Therapy and Preventive Strategies. Psychiatr Danub 2003; 15:201-207.*
12. Marčinko D, Martinac M, Karlović D & Lončar C: *Cholesterol serum levels in violent and non-violent young male schizophrenic suicide attempters. Psychiatr Danub 2004; 16:161-164.*
13. Marčinko D, Martinac M, Karlović D, Filipčić I, Lončar C, Pivac N & Jakovljević M: *Are There Differences in Serum Cholesterol and Cortisol Concentrations Between Violent and Non-Violent Schizophrenic Male Suicide Attempters? Collegium Anthropologicum 2005a; 30:153-157.*
14. Marčinko D, Rudan V & Begić D: *Psychotherapy in the era of neuroscience. Socijalna psihijatrija 2005b; 3:117-121.*
15. Marčinko D, Bolanča M & Rudan V: *Compulsive Buying and Binge Eating Disorder – A Case Vignettes. Progress in Neuropsychopharmacology and Biological Psychiatry 2006; 30:1542-1544.*
16. Marčinko D, Marčinko A, Jakovljević M, Đorđević V, Gregurek R, Henigsberg N, Folnegović Grošić P & Folnegović Šmalc V: *Serum cholesterol concentrations in suicidal and non-suicidal male patients suffering from persistent delusional disorder. Collegium Anthropologicum 2007a; 31:113-117.*
17. Marčinko D, Pivac N, Martinac M, Jakovljević M, Mihaljević-Pešić A & Muck-Šeler D: *Platelet serotonin and serum cholesterol concentrations in suicidal and non-suicidal male patients with first episode of psychosis. Psychiatry Res 2007b; 150:105–108.*
18. Marčinko D, Skočić M, Šarić M, Popović-Knapić V, Tentor B & Rudan V: *Countertransference in the therapy of suicidal patients – an important part of integrative treatment. Psychiatr Danub 2008a; 20:402-5.*
19. Marčinko D, Marčinko V, Karlović D, Marčinko A, Martinac M, Begić D & Jakovljević M: *Serum lipid levels and suicidality among male patients with schizoaffective disorder. Prog Neuropsychopharmacol Biol Psychiatry 2008b; 32:193-6.*
20. Marčinko D & Vuksan-Čusa B: *Borderline personality disorder and bipolar disorder comorbidity in suicidal patients: diagnostic and therapeutic challenges. Psychiatr Danub 2009; 21:412-25.*

21. Marčinko D: Family therapy in female patients suffering from borderline personality disorder and eating disorder with positive suicidal history. Presentation at the 1st International Congress on Borderline Personality Disorder (1-3 July 2010, Berlin).
22. Marčinko D & Bilić V: Family therapy as addition to individual therapy and psychopharmacotherapy in late adolescent female patients suffering from borderline personality disorder with comorbidity and positive suicidal history. *Psychiatr Danub* 2010; 22:211-214.
23. Marčinko D, Bilić V, Pivac N, Tentor B, Franić T, Lončar M, Medjedović Marčinko V & Jakovljević M: Serum cholesterol concentration and structured individual psychoanalytic psychotherapy in suicidal and non-suicidal male patients suffering from borderline personality disorder. *Coll Antropol* 2011; 35:219-223.
24. Marčinko D: Intersubjectivity and psychopharmacotherapy in the treatment of chronically suicidal patients. *Psychiatr Danub* 2011; 23:325-7.

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