Current Psychiatry

What is your patient's predicament? Knowing can inform clinical care

Persistent suffering may not be treatment resistance but a sign of inner turmoil

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Daniel D. Cowell, MD
Senior associate dean for graduate medical education
Professor of psychiatry
Department of psychiatry and behavioral medicine
Joan C. Edwards School of Medicine
Marshall University
Huntington, WV

Eight weeks after his wife died from an unexpected illness, Mr. M, age 55, remains overwhelmed, disconsolate, and virtually incapacitated. Previously in good health and a successful accountant, he struggles with low mood, guilt, anxiety, and anhedonia and is troubled by feelings of helplessness and hopelessness. "My life has been turned upside down," he says.

His primary care physician's support and encouragement—along with hypnotics, an anxiolytic, and antidepressants—have done little to improve his sleep and mood or relieve his emotional suffering. Mr. M has resumed work for financial reasons but returns home exhausted and demoralized, shunning the few friends who call. He has no history of a mood disorder or substance abuse. He has never expressed suicidal or homicidal ideation and shows no evidence of psychotic symptoms. He is referred to a psychiatrist for what his physician regards as a treatment-resistant depression.

When a patient's symptoms seem disproportionate to apparent stressors, I call this presentation a patient's predicament: a unique, profoundly unsettling, but poorly understood misgiving that something is wrong—perhaps terribly so—and that life may never be the same again (***Table, page 16***). Emotional flooding typically overwhelms these patients, and they are unable to express what they are experiencing.

For mental health professionals, the concept of a predicament is useful when working with patients who are moderately to severely ill or facing a life-diminishing or life-threatening illness.

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Patient's predicament

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Table

Patient in a predicament? Look for these 6 clues

Shows an unusual, disproportionate, or prolonged response to a distressing experience
Is incapacitated by persistent suffering and misery
Expresses feelings of drastic personal change, turmoil, life disruption, or hopelessness
Describes feeling lost, bewildered, and helpless or shows behavioral equivalents (such as aimlessness, loss of purpose)
Experiences difficulty achieving or maintaining an expected response to conventional and evidence-based treatment in the absence of psychosis
Demonstrates a clinical course punctuated by noncompliance with treatment that suggests the patient may have given up or feels unworthy of relief

Clinical Point

A clinician might conclude that a patient in a predicament has a treatment-resistant depression or is a 'difficult' patient

Affected by a 'field of forces'

I conceptualize Mr. M's unrelieved suffering as resulting from 1 or more threats—typically not fully appreciated by the patient—to important elements that undergird and sustain his sense of self. A predicament can be related to:

- Eric Cassell's conception of suffering that accompanies threats to an individual's sense of "personhood" in terms of its many domains[1]
- Thomas Merton's concept of emotional destabilization caused by threats to a person's "false self"[2]
- William Shaver's concept of a person's fragile "illusory self" and threats to "safety zones" that protect it.[3]

Patients experience a predicament as an emotional perturbation caused by something that has happened to them or is evolving from an acute loss, trauma, acute or chronic illness, unpleasant occurrence, or a recommended medical intervention. A predicament may embody multiple dimensions (biological, psychological, interpersonal, familial, occupational, spiritual, existential, economic, ethnic, and cultural).

Extrapolating from a social science concept, these dimensions comprise a "field of forces"—the interplay of internal and external, proximate, and global factors—that act on an individual (*Figure, page 20*). These forces:

- contribute to a person's sense of self and shape the manner in which that self is manifested to others—including the attending physician
- do not invalidate or discount the importance of the patient's transference but may cloud it and render it less "transparent."

Treatment resistance? A biomedical intervention focused on symptoms or a prominent symptom complex may be partially effective but result in a lowered threshold for recurrences. Although both patient and psychiatrist feel relief when symptoms abate, the individual is not necessarily healed. The disorder may continue to affect the patient, his family, his work performance, or other aspects of life.

One might conclude that this is a "treatment-resistant" depression or a "difficult patient" who has somehow not responded as anticipated. Yet, as author Norman Cousins observed from his experience with life-threatening illness, "patients are a vast collection of emotional needs, and understanding how patients are affected by serious illness as well as the illness itself paves the way for communicating without crippling the patient."[4]

Exploring the predicament

By sensitively exploring the personal story behind the patient's presenting symptoms (the predicament the patient is in), you become a nonjudgmental, affirming witness to that story. Simultaneously, you can urge the patient to consider how he or she might have arrived at the state of feeling overwhelmed (a process of demystification and early insight aptly described by psychotherapist Anthony Storr as "making the incomprehensible comprehensible"[5]).

This conceptualization of a patient's predicament regards the presenting problem as best understood and treated using a biopsychosocial model of causation (an amplification by George L. Engel of Adolf Meyer's concept of psychobiology) combined with a systemic view of how these dimensions

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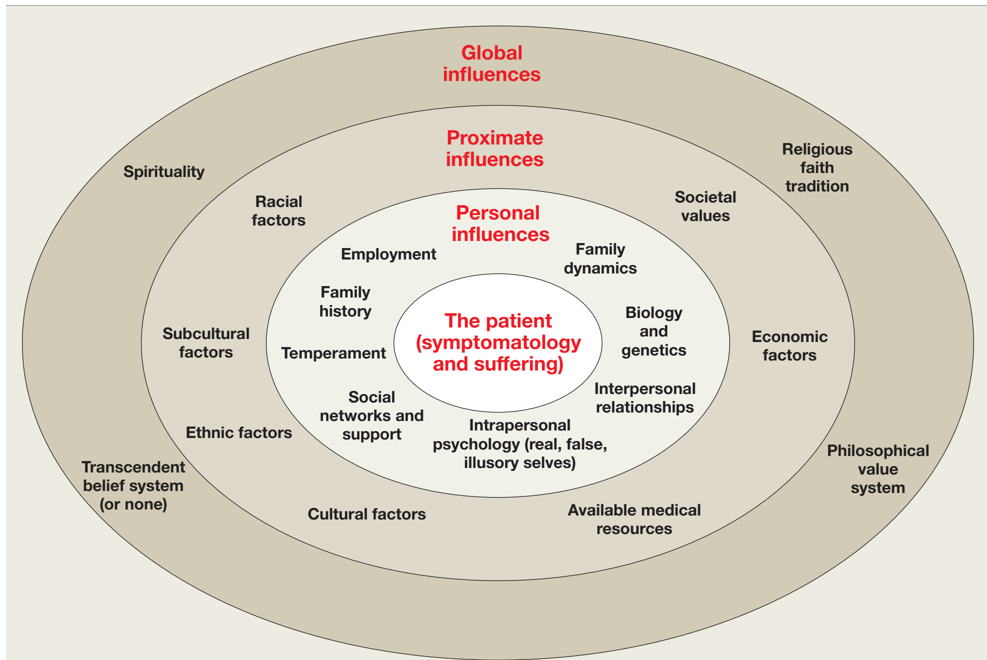
Patient's predicament

Figure

A predicament comprises an interactive 'field of forces'



The patient resides at the epicenter of inborn and external factors that make up his or her interactive, multidimensional environment. Concentric rings convey the interplay of personal, proximate, and global influences with which the patient must cope, whether or not he or she is aware of these influences.

Clinical Point

I do not believe skillful manipulation of neurotransmitters can cure this kind of multidimensional, cumulative misery

interact with each other, both within and upon the patient at any point in time.[6-8]

Dimensions of a predicament. A person functions and experiences his or her sense of self within a multidimensional environment. Mr. M's predicament embodies numerous dimensions:

- **Biological.** Pharmacologic interventions intended to contain Mr. M's distress have helped, but his acute grief and bereavement have merged into a severe major depressive episode.
- **Psychological, with counter-dependency.** Further exploration reveals that the abrupt loss of his wife unmasked a repressed, lifelong passive-dependency. Until she died, Mr. M had been able to compensate by the sense of control afforded by his profession and his pride in being self-reliant.
- **Spiritual.** The loss—and anger associated with it—seriously undermined Mr. M's faith because he felt that "God let my wife die."
- **Interpersonal and social.** Mr. M is aware that his wife's death severed his few connections with her friends and community activities.
- **Existential.** He feels distressingly alone in an unfriendly world in which he had never felt comfortable.
- **Ethnic, familial, economic, cultural, and societal.** Mr. M is struggling with the emergence of a life-long sense of inferiority, insecurity, guilt, and self-consciousness related to his immigrant parents' low socioeconomic status.

I do not believe that medicine and skillful manipulation of central nervous system neurotransmitters can cure this kind of multidimensional, cumulative misery. One is reminded of neo-Freudian Harry Stack Sullivan's view that "it takes people to make people sick, and it takes people to make people well."[9]

CASE CONTINUED

The 'real work' begins

Mr. M begins to improve as these factors are elicited and introduced in therapy as dynamic elements of the "field of forces" in which he finds himself struggling. This process es-

sentially detoxifies Mr. M's misery. He says, "I guess it's not surprising that I have felt as bad as I have, despite my doctor's help."

Insights gained—as well as medication and the psychiatrist's support and encouragement—are synergistic, and his mood slowly lifts. Mr. M now can begin the difficult work of achieving a more stable sense of security and a closer approximation to his undiscovered "real self" that has eluded him.[6] He also is beginning to perceive how his wife's death has revealed a pre-existing dependency—with persistent fears of abandonment—that left him vulnerable to losses.

Exploring a patient's predicament is not symptom-focused per se. Some psychiatrists may feel they don't have time to explore the nature of a patient's predicament because of managed care constraints or lack of training and experience in using explorative and interpretive psychodynamic techniques. Psychiatrists who employ cognitive-behavioral therapy and related approaches may be uncomfortable or unfamiliar with a biopsychosocial and systems orientation to patient evaluation and treatment that considers the entire context—past and present—in which symptoms emerge.

One could argue, however, that not exploring a patient's predicament would correspond biomedically to identifying the presence of symptoms (such as anemia, hypertension, a phobia, or orthopnea) but not basing treatment on comprehending their pathophysiology.

Serving the patient's interests. In psychiatric practice, patients' interests usually are best served by treatment that is based on understanding their predicaments while refraining from being too distracted by vivid symptoms the components of their predicaments can produce. A biopsychosocial and systemic orientation is clinically useful because:

- The clinician develops a greater connectedness, empathy, and therapeutic leverage from apprehending the field of forces affecting the patient and fashions a treatment plan that takes these forces into

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Clinical Point

Not exploring a patient's predicament is like identifying anemia but not basing treatment on its pathophysiology

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Related Resource

- Reiser D, Rosen D. Medicine as a human experience. Baltimore, MD: University Park Press; 1984 (an excellent reference on George L. Engel's biopsychosocial concept, the care of patients, and the doctor-patient relationship).

Disclosure

Dr. Cowell reports no financial relationship with any company whose products are mentioned in this article or with manufacturers of competing products.

consideration. Mr. M's plan, for example, might include spiritual and financial counseling in addition to conventional treatment for a mood disorder.

- The patient feels the psychiatrist is interested, skilled, and attentive enough to inquire about troublesome areas the patient might or might not have thought were related to his condition.
- The psychiatrist is gratified to see the clinical benefit that can come from recognizing and understanding the patient's plight when developing a comprehensive treatment plan.

As you gain experience in using this concept, the uniqueness of each person's predicament will become clear more quickly, even as you encourage the patient to "connect the dots" of his suffering in terms of his personal biopsychosocial history. In doing so, patients will gain a measure of control over situations they had considered overwhelming and mystifying.

I do not consider my assessment of a new patient adequate until I have at least sketched out as many of the elements contributing to his or her distress as I can.

What about a patient's symptoms?

An objection to a biopsychosocial/systemic approach is that some patients will resist attempts to redirect attention away from their presenting complaints. This very objection explains why you need to understand what forces underlie a patient's "death grip" on his or her symptoms, while refraining from concluding that the patient has a treatment-resistant depression, requires ever more sophisticated polypharmacy, or is "untreatable."

Finally, patients with a serious illness almost invariably experience a predicament—whether recognized or not—and it may render the clinical outcome less than satisfactory if you do not identify its elements and bring them into therapy when appropriate. Regardless of presenting symptoms or diagnosis—and independent of your theoretical orientation—experience suggests the usefulness of assuming every new patient is in a predicament. If you cannot address the predicament early in therapy, it is usually possible to do so after you and the patient develop a therapeutic relationship and you have used other interventions to lower the intensity of the target symptoms.

By helping patients understand more fully their unique predicaments, you can reduce their burdens, foster realistic hopefulness, and be gratified by having truly connected with what patients experience as serious threats to their sense of self.

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Clinical Point

As you gain experience in using this concept, each person's unique predicament will become clear more quickly

Bottom Line

Done patiently and with sensitivity—even if only for relatively brief appointments over time—the psychiatrist who undertakes to apprehend a patient's predicament cares for the whole person. This is truly the art of medicine, skillfully practiced while employing the best medical science has to offer.