A long time ago in a clinic far, far away….

A long time ago….

- A 63 yo male w/ renal carcinoma s/p nephrectomy, severe MDD, ADHD, memory deficits, tobacco use disorder and insomnia presents with ex-wife for follow-up
- Pt has been struggling w/ depression since mid-40s

A long time ago….

- Depression became very severe in 2016 and suddenly forgot how to play the piano despite being a professional musician for many years
- Seemed to have occurred not long after his partner leaves him
- Claims that he has absolutely no recollection of this very significant and long-term relationship; unclear why it ended

A long time ago….

- 2017 his neighbors prompted ex-wife to visit an found him in a state of disarray where he was unwashed, unkempt, had been eating only hot dogs and cocoa puffs
- He was in a semi-vegetative depression, answering questions with only brief responses and having difficulty with word finding
- She brought him back to San Diego to live with her and their 2 college age children

A long time ago….

- In 2017, he received a full round of ECT followed by weekly maintenance ECT for nearly a year with very little effect
- After ECT, he was trialed on multiple psychotropic medications for treatment of intractable depression with no significant positive effect

A long time ago….

- Pt first seen at UCSD in 2019 and was on olanzapine 10 mg PO Qnight, paroxetine 30 mg PO Qday and clonazepam 0.5 mg PO BID
- Added methylphenidate 5 mg PO BID given past history of ADHD-Inattentive type despite concerns for bipolar disorder and absolutely no indication of symptoms of ADHD at that time, gave it for “energy”
- However, had “remarkable” recovery almost immediately where he started to be more interactive and played the piano again so increased methylphenidate to 10 mg PO BID

A long time ago….

- Talked about tapering off clonazepam and immediately his presentations worsens including mood, sleep and energy
- Switched to long acting methylphenidate and attempts to taper off clonazepam are halted by the pt; no change
- Misses next appointment with psychiatrist

A long time ago….

- Gets higher dose of methylphenidate and switched to IR
- Attempts to taper off clonazepam again by small amount and pt's calls 4 days later stating his mood and energy are still low
- Methylphenidate titrated to 20 mg QAM and 10 mg Noon
- Clonazepam taper was never continued

A long time ago….

- Pt on paroxetine 30 mg po QAM, clonazepam 1 mg po QHS, Ritalin 20 mg po BID Ritalin 10 mg po at noon, olanzapine 10 mg po QHS for the next almost 2 years
- Per psych notes over the last 2 years, pt seemed to always be teetering on the edge of a cliff and flirting with impending decline

A long time ago….

- Currently, he does not eat w/o being asked to by ex-wife
- Patient states "I don't know what I feel, I feel bad, I feel a lot of anxiety." Has low appetite, energy level
- Regarding anxiety, patient states he "becomes frozen, like driving to a location makes me totally panic."
- Sleeps 6-8 hours

A long time ago….

- States his anxiety is relieved when he takes more Ritalin.
- Denies SI/HI/AVH/paranoia. Denies past SA.
- No fluctuations, depression overall remains the same over the last few years. Notes when he comes off meds he feels worse, no side effects he is aware of.

Past Psychiatric History

- Diagnosed w/ depression, anxiety and ADHD
- No suicide attempts
- Hospitalized at SMV in 2017 for nearly a year w/ ECT throughout
- Denied history of trauma

Additional History

- He has a history of alcohol abuse from approximately age 15-25. He received treatment at the McDonald center and has been mostly sober since then, more than 35 years
- In early May, 2019, he underwent neuropsych testing - memory loss is most likely a result of depression

Past Psychiatric History

Past Med Trials

- Paroxetine-current, not helping, 30 mg daily
- Clonazepam-currently taking 1 mg daily, has taken up to 4 mg daily in the past, tapered down but unable to stop completely
- Mirtazapine 15 mg at bedtime, not effective
- Quetiapine 150 mg at bedtime, not effective
- Buspirone, not effective Risperidone 1-2 mg at bedtime
- Escitalopram 30 mg daily, not effective
- Brexpiprazole-not effective
- Hydroxyzine (Vistaril)-not effective
- Sertraline-used this for many years with some success but it stopped working and was re-started multiple times with no success.
- Aripiprazole-not effective
- Olanzapine
- Methylphenidate

Family and Social History

- Mother w/ depression and possible bipolar type disorder
- Daughter may have bipolar disorder
- Living w/ ex-wife and her family, goes on vacations with that family

Mental Status Exam

- Physical appearance: mildly disheveled, beard (not well groomed), soiled clothing, graying hair, glasses, casually dressed, sitting down in chair often times w/ downcast eyes and hunched over
- Relatedness: somewhat engaged when spoken to directly, otherwise pt defers to ex-wife
- Eye contact: poor
- Attitude: mildly cooperative, not fully engaged
- Speech quality: lower volume, slower rate, somewhat diminished prosody, speaks more loudly w/ a frantic tone at times
- Motor behavior: slowed, becomes more activated at times
- Mood: "I don't know what I feel, I feel bad, I feel a lot of anxiety"
- Affect: incongruent, restricted and does not appear overtly anxious despite saying at times that he was having high degrees of anxiety

Mental Status Exam

- Thought process: superficially linear/logical/goal-oriented
- Thought content: no evidence of psychotic symptoms, denied AVH; did not appear to be RIS/internally preoccupied
- Suicidal ideation: none
- Homicidal ideation: none
- Orientated to: Person: yes Place: yes
- Attention/Concentration: grossly intact
- Memory: mildly impaired
- Insight/judgement: pt seeking help for mental health issue Judgment: pt seeking help for mental health

Mental Status Exam

- pt would become acutely anxious when discussing concerns regarding his use of stimulants and benzos; otherwise pt was calm and not very engaged throughout the interview
- Also became anxious when talking about new options that may work
- Ex-wife was given role of historian with pt affirming what she says
- Ex-wife had anxious affect and pleading tone throughout interview
- Ex-wife became very anxious and pleading when pt became anxious

Initial Assessment

- Given past history of possible hypomanic episodes and daughter w/ bipolar 1 disorder, it is possible that patient's depressive symptoms is not due to a traditional MDD-type picture but may be closer to a bipolar-spectrum type disorder.
- It is also odd that patient reports very discrete losses of memories w/ otherwise intact memory (patient was able to recall things in the distant past and recently w/o problems) which is not typical of depression.
- Patient also reported a loss of ability to play the piano suddenly w/o relation to effort which is also atypical of a depression and, combined with his reported memory loss, could represent a neurological phenomenon such as stroke or perhaps functional neurological disorder.
- There is concern that stimulants may be exacerbating patient's reported anxiety and that patient may be experiencing some physical dependence on stimulants w/o therapeutic benefit given his statement that his anxiety rises when his stimulants wear off and he feels better when he takes more than prescribed.

Assessment

- DSM 5 Diagnosis
  - Unspecified mood disorder rule out severe/recurrent MDD vs MDD w/ atypical features vs bipolar 2 disorder
  - Stimulant use
  - Memory loss and possible apraxia

What is going on?!

- What is going on w/ his meds?
- Why is his medical treatment history so extensive?
- What's going on w/ his relationship with his family?

Countertransference and Prescribing

Episode IV

Fred Liu

SEARCH YOUR FEELINGS...

Countertransference

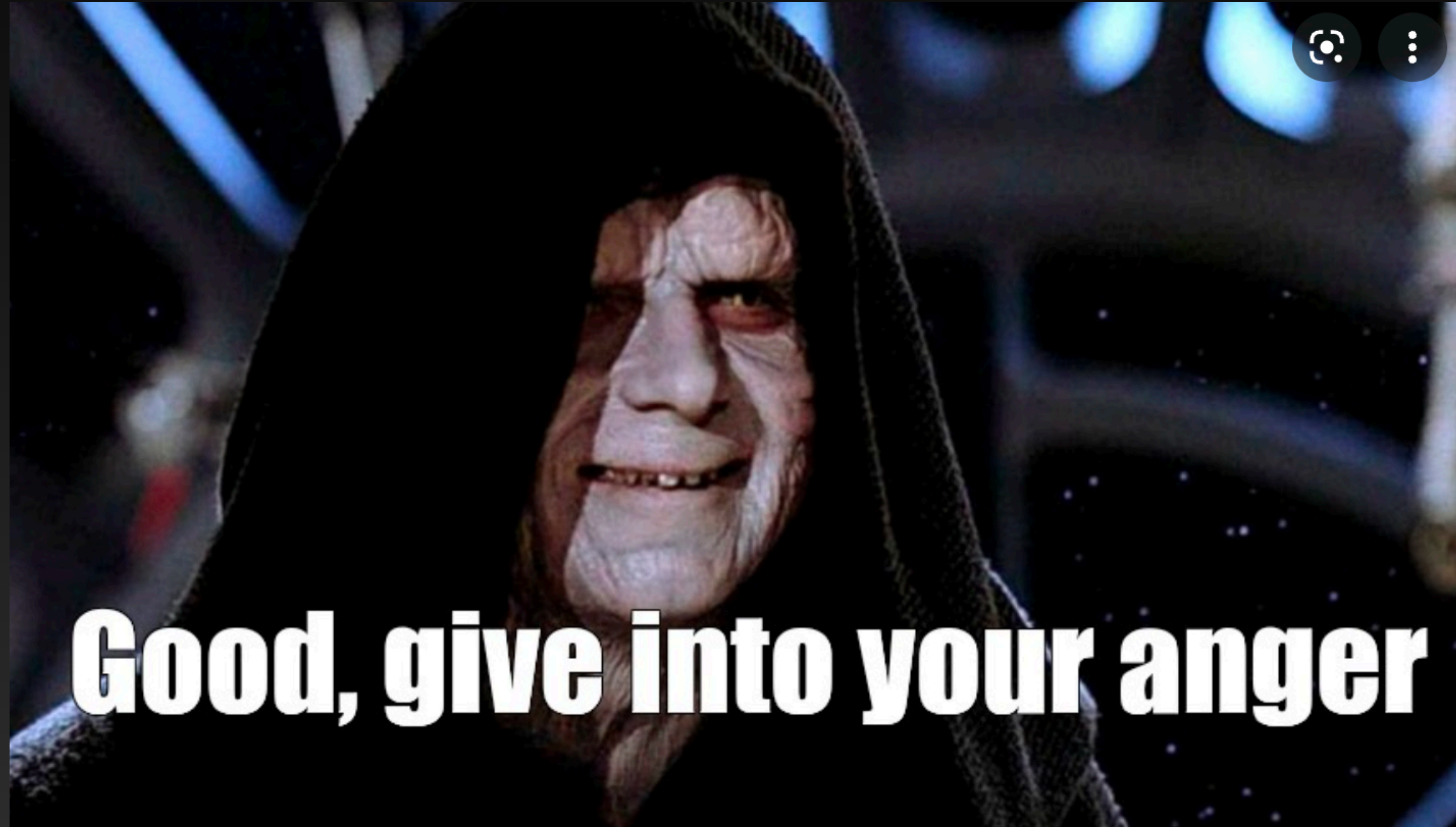
- The psychotherapy literature describes two definitions of countertransference: classical and total
- The classical definition identifies the clinician's past neurotic conflicts as the source of countertransference while the totalist definition identifies the past and present experiences of the patient and clinician interaction as the source
- Countertransference '[entails] a jointly created reaction in the clinician that stems in part from contributions of the clinicians past and in part from feelings induced by the patient's behavior.'

Countertransference

- During the 1950s, a wider definition of the concept was introduced
  - “Totalistic” definition includes all the emotional reactions therapists have toward their patients and is the most commonly used definition today
  - Therapists’ emotional reactions are considered important tools in psychodynamic therapeutic processes
  - Psychotherapists’ countertransference reactions may reflect important aspects of patients’ personalities and help them to understand the problems with which the patients struggle
- Diagnostic categories, in themselves, and age or gender were not related to therapists’ countertransference feelings

Countertransference

- Different clusters of personality disorders were associated with different countertransference reactions across therapeutic approaches, and that the therapists could make diagnostic and therapeutic use of their own responses.
- Cluster A personality disorders were associated with both disengaged and criticized/mistreated factors, cluster B personality disorders were associated with overwhelmed/disorganized and criticized/mistreated factors, and cluster C personality disorders were only associated with a parental/protective factor.


Good, give into your anger

GIVE INTO YOUR HATE
EMBRACE THE DARK SIDE OF THE FORCE

Difficult Patient

- Multiple somatic complaints
- Anger or irritability
- Frequent doctor visits/calls
- Noncompliance
- Depression
- Anxiety
- Agitation

Difficult Patient

- Drug-seeking behavior
- Excessive requests for attention
- Physically or verbally aggressive behavior
- Sabotaging care
- Wandering/pulling out lines

Dependent Clingers

- Clingers escalate from mild and appropriate requests for reassurance to repeated, perfervid, incarcerating cries for explanation, affection, analgesics, sedatives and all forms of attention imaginable
- They are naive about their effect on the physician, and they are overt in their neediness.
- What is common to them as a group is their self-perception of bottomless need and their perception of the physician as inexhaustible.

Dependent Clingers

- Such dependency may eventually lead to a sense of weary aversion toward the patient.
- When the doctor's stamina is exhausted, a referral for psychiatric examination may be adamantly put forth in frustrated tones that the patient (correctly) interprets as rejection.
- Psychiatric referrals made in this context are destined to fail utterly.

Dependent Clingers

- Early signs of the clinger are the patient's genuine gratitude, but to an extreme degree, and the doctor's feelings of power and specialness to the patient, an emotion not unlike puppy love.
- Later on, the doctor and the patient have different feelings toward each other.
- The doctor becomes the inexhaustible mother; the patient becomes the unplanned, unwanted, unlovable child.
- Early identification of this situation is helpful, but its corrective may be applied at any point short of a complete blowup.

Dependent Clingers

- The clinger must be told as early in the relationship as possible, and as tactfully and firmly as possible, that the physician has not only human limits to knowledge and skill but also limitations to time and stamina.
- Written follow-up appointments are placed in the patient's hand, the doctor says, "so long," and never, "good-bye," and the patient is firmly reminded not to call except during office hours or in an emergency.
- This approach is not cruelty or rejection.
- It is in the best interest of patient care to protect the patient from promises that cannot be kept and from illusions that are bound to shatter.

Entitled Demanders

- Demanders resemble clingers in the profundity of their neediness, but they differ in that rather than flattery and unconscious seduction they use intimidation, devaluation and guilt-induction to place the doctor in the role of the inexhaustible supply depot.
- They appear less naive about their effect on the physician than clingers and buttress their hold on the doctor by threatening punishment. The patient may try to control the physician by withholding payment or threatening litigation.
- The patient is unaware of the deep dependency that underlies these attacks on the doctor.

Entitled Demanders

- The physician, in turn, does not recognize that the hostility is born of terror of abandonment.
- Moreover, such patients often exude a repulsive sense of innate deservedness as if they were far superior to the physician.
- This attitude is to shield them from awareness that the physician seems to have power over life and death.
- Obviously, this sense of innate and magical entitlement to everything that is wanted is depressing (and therefore often enraging) to the busy physician, who may have had to surrender many dreams of omnipotence and omniscience over the years of training.
- The physician becomes fearful about reputation, enraged that the patient is not cooperative and grateful and - eventually - secretly ashamed, as if the patient's devaluating demands were realistic.

Entitled Demanders

- But this very "entitlement," repulsive as it may be, is resorted to by the patient in an effort to preserve the integrity of the self in a world that seems hostile or during an illness that seems terrifying.
- "Entitlement" serves for some persons the functions that faith and hope serve in better adjusted ones.
- The usual impulse toward entitlement is a wish to point out suddenly and devastatingly that the patient has earned little, medically or in larger society, and deserves little.
- Entitlement is such a patient's religion and should not be blasphemed.

Entitled Demanders

- The physician should never gainsay the patient's entitlement.
- Rechannel it in the direction of the indicated regimen.
- A doctor might say, I know you're mad about this and mad at the other doctors. You have reason to be mad. You have an illness that makes some people give up, and you're fighting it. But you're fighting your doctors too. You say you're entitled to repeated tests, damages for suffering and all that. And you are entitled entitled to the very best medical care we can give you. But we can't give you the good treatment you deserve unless you help. You deserve a chance to control this disease; you deserve all the allies you can get. You'll get the help you deserve if you'll stop misdirecting your anger to the very people who are trying to help you get what you deserve - good medical care.

Entitled Demanders

- Such an approach acknowledges the patient's entitlement not to have unreasonable demands met or to bully others but to what is realistically good care.
- The physician must be aware of the litigiousness of such patients and may to a certain extent practice "defensive medicine," but need not be bullied or actually defensive.
- The doctor also should beware of getting entangled in complicated logical (or illogical) debates with the patient.
- Rather, there should be tireless repetition of the theme of acceptance that the patient deserves first-rate medical care.

Manipulative Help-Rejecters

- They appear to have a quenchless need for emotional supplies but are not seductive and grateful and are not overtly hostile.
- They actually seem the opposite of entitled; they appear to feel that no regimen will help, appearing almost smugly satisfied, they return again and again to the office or clinic to report that, once again, the regimen did not work.
- Their pessimism and tenacious nay-saying appear to increase in direct proportion to the physician's efforts and enthusiasm.
- When one of their symptoms is relieved, another mysteriously appears in its place.

Manipulative Help-Rejecters

- Apparently, what is sought is not relief of symptoms. What is sought is an undivorcible marriage with an inexhaustible caregiver.
- Such patients seem to use their symptoms as an admission ticket to a relationship that cannot be sundered so long as symptoms exist.
- Thus, they are often accused of "masochism" and are said to be reaping unjustified "secondary gain."
- Such patients frequently deny being depressed and typically refuse referral to a psychiatrist.

Manipulative Help-Rejecters

- These behaviors elicit first in the physician anxiety that a treatable illness has been overlooked, next irritation with the patient and, finally, depression and self-doubt in the doctor.
- But the depression originally is not in the doctor - it is usually in the patient.
- Although it is important to suspect depression in the help-rejecter, it is hazardous to imply that he or she is too dependent or immature to get better or that unconscious manipulation is going on.
- Such an approach simply precipitates a new round of doctor shopping.

Manipulative Help-Rejecters

- Rather, it may be helpful to "share" the pessimism to say that the treatment may not be entirely curative.
- Even if it is, regular follow-up visits (hence, at intervals determined by the doctor) are put forth as necessary for the maintenance of any modest gains.
- In this way, the patient's fear of losing the doctor may be partly allayed, and the patient may be able to follow the treatment plan without fear of engineering his or her own abandonment.

Manipulative Help-Rejecters

- Pathologic dependency presents in one of its extremes as manipulativeness - an intense, covert, contradictory, self-defeating attempt to get needs met.
- It is the behavioral manifestation of a need by the patient to get close to but at the same time to maintain safe distance from sources of emotional support.
- Limits on unrealistic expectations, limits on demanding hostility and - most of all - repeated appeals to entitlement are again invoked.

Manipulative Help-Rejecters

- The doctor, by a consistent, firm manner, conveys that the patient will not be allowed to become so close as to be engulfed nor so distant as to starve.
- Gentle, simple reasoning with this patient is better than complicated explanations.
- To refer help-rejecters for psychiatric evaluation is never easy.
- If a psychiatric illness is thought to be present, one tactic for helping the patient accept psychiatric consultation is to schedule another appointment with the patient for a time after the consultation is to occur.
- In this way, the doctor can convey that the consultation is an adjunct to medical treatment, not abandonment.

Back to the Case

- Sensations of helplessness, overwhelmed, failure, impossibility, fear, fragility, desperation, need to do everything to help ex-wife, uncomfortable
- Ex-wife was almost like a puppet at times
  - Pt would pull on strings w/ key words
  - Ex-wife becomes desperate and pleading while pt sits smugly in the corner w/o much affect

Back to the Case

- It is possible that the extensive treatments endured by the patient may have been a result of the helplessness felt by his other doctors perhaps driven by his need for emotional supply
- His diagnosis may actually be much simpler than presented but still difficult to manage given years of this dynamic

Back to the Case

- Set firm limits, give honest recommendations, manage own anxieties and think clearly, reassure, set regular visits
- In this case may need to slowly remove stimulants first, then benzos, then decrease olanzapine

MAY THE FORCE
BE WITH YOU!

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