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The Role of Clinical Psychiatry in Nurturing Autonomy in Female Japanese Patients with Pathological Personality Traits

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Abstract

Few studies have examined patients with pathological personality traits in terms of their competency to exercise autonomy, despite the increasing number of these individuals who visit psychiatric clinics in Japan. The purpose of this study was to assess such patients' competencies using medical record data focusing not only on the therapeutic relationship but also on the patients' social relationships throughout their life histories. Two patients were evaluated: one with borderline personality disorder and another with the "as if personality", a concept of personality prototype proposed by Helene Deutsch in 1942. Their clinical materials were analyzed from psychosocial viewpoints. I attempted to identify the points in their lives at which any competency weaknesses originated. I further discuss their competencies in decision making and exercising autonomy using psychoanalytic theory, in particular Winnicott's contributions. Finally, I propose the role of contemporary psychiatry in nurturing patients' autonomy, in order to help them live more comfortably in Japanese modern society.

Keywords: Autonomy; Personal; Competency; Mental; Personality; Psychoanalytic theory; Psychiatry

Introduction

Japan has recently seen an increase not only in the number of people visiting psychiatric clinics but also in the proportion of these individuals who suffer from distresses that can be regarded as having been caused by pathological personality traits. At first sight, these patients, in particular females, appear to be competent in decision making, yet they sometimes seem to have difficulty exercising their autonomy.

As noted by Grisso and Appelbaum [1], "Western societies embrace autonomy as an ideal not just because the exercise of self-determination is likely to advance personal well-being, but also as a good in itself." Respecting patient autonomy has been widely accepted as one of the four crucial ethical principles in practicing clinical psychiatry [2]. In Japan the importance of respecting autonomy has gained attention only recently, as individualism seems to have become ingrained in Japanese culture. Beauchamp writes that "autonomy thus means freedom from external constraint and the presence of mental capacities such as understanding, intending, and voluntary decision-making capacity [2]." In other words, people who are free from both external and internal constraints are regarded as being capable of exercising autonomy. In the "Bioethics Core Curriculum," published by the United Nations Educational, Scientific and Cultural Organization (UNESCO [3]), autonomy is defined as "individual capacity for self-determination, independent decisions, actions, and evaluations", with the responsibility to be aware "of one's obligation to make decisions and to act appropriately on the basis of certain commitments."

As Beauchamp [2] writes, "during and after the 1970s, requirements of informed consent gained a foothold in medicine, and seem to be justified by obligations of respect for autonomy." Autonomy and informed consent cannot be considered independently of each other. Grisso and Appelbaum [1] put forward three elements required in the process of informed consent: "disclosure of information by clinicians," that this disclosure occurs "within a context that allows voluntary choice", and that the consent is "made by a patient who is competent to decide." Four functional abilities are related to competencies: "understanding of information that is disclosed in the informed consent process", "appreciation of the information for one's own circumstances", "reasoning with the information", and "expressing a choice [1]." That is to say, if someone is lacking in decision-making competencies, the processes of informed consent cannot be carried out, and furthermore, respecting autonomy becomes a lesser priority.

It does not necessarily follow that a patient with a particular mental disorder does not have decision-making competencies [1]. These competencies, certainly influenced by the severity of mental disorders such as schizophrenia and major depressive disorder, are generally regarded as partially impaired to some degree depending on the individual, but other competencies are not susceptible to these disorders and survive as operationally intact. There is some debate as to whether patients with depressive disorders have competencies in judgment and decision making [4]. Although mental disorders per se do impair patients' autonomy, it is generally accepted that respecting autonomy should not be completely disregarded [5].

In this study we focused on personality disorders, which have not been fully investigated with regard to autonomous decision-making competencies. This is probably because patients with these disorders usually do not have impaired intelligence or severe, persistent cognitive distortions such as unremitting delusions. Therefore, there had been a tacit, shared consensus that they be regarded as competent and that their autonomy should be put before their own best interest. However, as mentioned above, this view seems debatable. It is crucial to examine these patients' competencies in exercising autonomy using a clinical approach, and further, if they are lacking in these competencies to some degree, to identify the cause.

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The majority of patients with personality disorders in Japan seem to have DSM-IV Axis I disorders as well, such as eating disorders or major depressive disorder. Psychiatrists in general tend to focus more on Axis I disorders than personality disorders (Axis II), and mainly provide pharmacotherapy. They tend to be reluctant to concern themselves with personality characteristics. When a psychiatrist does not consider a decision made by a patient to be in that patient's best interest, the patient's competencies in autonomous decision making would become one of the pivotal arguments [1]. Also, it is particularly necessary that these patients deepen their self-knowledge under the cooperation of a psychiatrist, and not simply accept the psychiatrist's pharmacotherapy prescriptions. Within the psychotherapies, the therapeutic relationship is one of the most vital resources. When a psychiatrist and a patient form a "therapeutic alliance" [6,7] and together explore the patient's personality, the patient's autonomous participation as an independent individual is one of the ideal prerequisites. According to Freud [8], the father of psychoanalysis, ego, and in particular the conflict-free ego sphere [9], executes every domain of cognition, emotion, thought process, and behavior. The 12 ego functions proposed by Bellak, Hurvich, and Gediman [10] are "reality testing", "judgment", "sense of reality of the world and of the self", "regulation and control of drives, affects, and impulses", "object relations", "thought processes", "adaptive regression in the service of ego", "defensive functioning", "stimulus barrier", "autonomous functioning", "synthetic-integrative functioning", and "mastery competence", all of which are vital elements in forming therapeutic alliances, making autonomous decisions, and taking responsibility for the results of these decisions. It can be assumed that an individual with a personality disorder has varying degrees of difficulty exercising the above 12 elements of ego function. In this article, I evaluate from several perspectives the competency of patients with personality disorders to exercise autonomy, and further discuss how the results can be applied to clinical settings.

Methods and Materials

Two of my patients were selected as subjects for analysis. I had been providing these patients with 45 minute psychotherapy sessions once per week, and therefore expected to be able to obtain sufficient information. The first patient, Ms. A, was diagnosed with borderline personality disorder. The other, Ms. B, was diagnosed with narcissistic, dependent, and borderline personality disorders under the DSM-IV criteria; using an alternative conceptual framework, the "as if personality" proposed by Deutsch [11] was a good fit for this patient's personality characteristics. The selected two patients seemed to interact with other people in completely different ways. However, behind their attitudes and behaviors within their interpersonal relationships, they appeared to share similar psychological motivations, which would be related to their deep-rooted personality pathologies. These pathologies were regarded as the critical factors which damage their competencies in exercising autonomy and decision making. Therefore, identifying the common relationships between these competencies and the two patients' personality pathologies, based on detailed analysis of the patients seemed to provide a basis for discussing the ability to exercise autonomy and the existence, or lack of, competencies in patients with personality pathologies in general.

Study materials were selected from the patients' medical records between January 11, 2008 and August 31, 2012. The research protocol was approved by the Ethical Committee of Kumamoto University (Institutional Review Board).

Analysis procedures

The analysis comprised three steps. The first was to select the clinical records considered to be related to patients' decision-making competencies as well as those of exercising autonomy within the therapeutic relationship and their interpersonal relationships outside of therapy. The second was to briefly describe their life histories, then to analyze the aforementioned competencies from psychosocial viewpoints, in particular utilizing psychoanalytic theories. Finally, as general discussion, I will propose how we should consider the competencies of patients with personality disorders in the areas of decision making and exercising autonomy, and how psychiatry can best serve them.

Result

Case 1

Ms. A was 25 years old when she first visited the author. She displayed abandonment fear and self-destructive behaviors, including threats to commit suicide, some of which were acted upon in the form of overdose. Other borderline personality features were also manifest.

I first selected two episodes representative of Ms. A's competencies in decision making and exercising autonomy within her therapeutic relationship.

Episode 1: Ms. A had lived indoors for three years, with a reversed diurnal pattern of behavior. She also had an eating disorder, specifically binge eating at night due to intolerable emptiness and loneliness. In addition, she experienced anger fueled by the recollection of how she was treated unfairly by many people, including her family members, relatives, classmates, school teachers, and colleagues. She frequently took her anger out on her parents, especially her mother. As a consequence, she experienced painful disregard, rejection, and criticism from her parents, often resulting in self-destructive behaviors. Her relationship with her parents had been this way since her mid-adolescence.

During psychotherapy, she asked me to prescribe her medication that would alleviate her irritability. In conversation she expressed the opinion that it was meaningless to live because she had no one to talk to, and that an attempt to engage with society by working part-time would be futile as she had been unable to hold down a job for more than three months. Her main reason for quitting was excessive sensitivity in interpersonal relationships, which will be explained in detail later.

In accordance with her request for pharmaceuticals to alleviate irritability, I proposed a very low-dose atypical antipsychotic. I gave her the choice of four antipsychotics, informing her of both their benefits and adverse effects. Ms. A chose drug X, which usually reduces irritability quickly and has antidepressant effects. However, the main adverse effect is increased appetite and concomitant weight gain. Despite this adverse effect, she said she wanted to take X. I advised her not to eat a lot even if she became hungry; however, she was not able to manage her increased appetite and diet. Food consumption was further exacerbated by loneliness, emptiness, and anger, caused by her perceptions of rejection and contempt by others throughout her life. She gained 10 kg in a month.

As a result, she was furious: "Why did you prescribe me the medicine? Why did you not tell me that I was gaining weight? If you had, I would have stopped taking the medicine. It is inconceivable that you did not notice my increased body weight!" Of course, she had a body weight scale at home and recognized her changing weight, but she was angry because I did not inform her explicitly. As well as taking her

anger out on me during psychotherapy, she also emailed me expressing her resentment. It seemed difficult for her to hold her emotions in check until the next session.

Episode 2: I thought that it was not desirable for Ms. A to stay indoors all the time because her home was not an emotionally comfortable place, and as such was an additional stressor. I therefore proposed she participate in a community outside the house. I gave her the option of a psychiatric recreation and rehabilitation center or a vocational rehabilitation center, both for patients with mental disorders. I also explained that this was a chance to experience and subsequently develop coping strategies for interpersonal relationship stresses within a community, although the initial exposure to the distresses would be difficult. I made it clear that the decision was up to her. Although I told her that more responsibility was required of her in the vocational rehabilitation center than in the psychiatric recreation and rehabilitation center, she decided to attend the vocational rehabilitation center where she could earn a wage, which was not the case at the psychiatric recreation and rehabilitation center. She said that in the future she wanted to be economically independent, and would utilize the vocational rehabilitation center for a few years as one of the steps towards becoming employed in a company office.

Initially, the opportunity to display her natural talents (Ms. A was artistically gifted) drew praise from other members, in particular the men. This seemed to help her recover her self-esteem. However, within two weeks she began to perceive what others were saying as negative and became distressed. She was extremely sensitive to others' comments, and felt she was being insulted, not only by fellow members but also by staff. Even praise was perceived in a negative light. During the weekend when the rehabilitation center was closed, the events of the week flooded her mind, making her furious. Her anger was intensified when her parents were not empathetic, which was most of the time. During psychotherapy, as well as by email, she directed her anger towards me as the person who had recommended attending vocational rehabilitation. She said I should regret my recommendations. She felt as if I had coerced her into attending the rehabilitation, even though I had obtained informed consent after explaining to her both the beneficial and stressful aspects of the psychiatric recreation and rehabilitation center and the vocational rehabilitation center and considering these issues together with her. Ms. A's seemingly unreasonable responses will be discussed later.

Life history: To help the reader understand Ms. A's cognition, emotion, and behaviors, I will briefly describe her life history. She had no memory of bonding with her mother prior to pre-adolescence. Ms. A was quiet, and the lack of any meaningful mother-daughter relationship precluded Ms. A from going to her mother with her troubles. She had two older brothers. Her parents praised her two brothers for their comparatively high academic school performance relative to Ms. A. Almost all her opinions and proposals were disregarded, and her parents, in particular her mother, supported her brothers in conflicts between Ms. A and her siblings. With regard to most of the events Ms. A recounted, I deemed her opinions, proposals, and reactions at the time to be rational.

When she was a junior high school student, she was not able to form peer relationships and this harmed her school life. She said to me later in psychotherapy that she had stopped attending school sometime in the first term of her first year, as she had been emotionally wounded by the treatments of her seniors during club activities. She said that her schoolmates had not recognized how hurtful their actions had been, and that they did not respect her.

She was reluctant to go on to senior high school because she had no interest in studying, and importantly her mental capacity had been drained by stressful relationships with her previous schoolmates. She therefore enrolled in a senior high school whose mode of study was mainly by correspondence, and she was only required to attend classes twice a month.

Just before graduating from senior high school, she began to immerse herself in sexual relationships with men she had come to know through the Internet as well as some who picked her up on streets. She always felt that they treated her as unimportant and then became furious towards them.

At one point, Ms. A became acquainted with a man who loved her and supported her emotionally. However, she controlled and manipulated him arbitrarily, and eventually he left, saying "I cannot become your mother." Again, Ms. A experienced the abandonment she feared, leading her to sadness and rage.

It was then that she first visited my hospital, and I recommended that she undergo psychotherapy in addition to pharmacotherapy. Ms. A forced her mother to drive her to the hospital, despite being capable herself, an act of control designed to fill a gap in maternal emotional support.

After joining the vocational rehabilitation center, she swiftly devalued female staff members as well as female patients due to intense feelings of envy towards them. It seemed to be difficult for her to establish stable relationships with women. She easily came to feel romantic emotions towards male staff members and patients, characterized by intense dependency and need for approval. A romantic relationship with a patient ended in familiar fashion.

Interpretation: I would first like to discuss Ms. A's competencies in decision making and exercising autonomy. She actually agreed to take the antipsychotic, as well as to attend the vocational rehabilitation center, after being provided with an explanation regarding both the negative and beneficial aspects of her options. In terms of the four fundamental abilities concerning competencies [1], although she seemed to be able to "understand the information that was disclosed", she was not able to appropriately "appreciate the information for her own circumstances." To explain in detail, it was difficult for her to connect her past experience and personality to the potential outcome of a choice. I was concerned about her ability to "appreciate" the disclosed information. Therefore, prior to her attending the vocational rehabilitation center, I again explained to her that at this center she might experience distress caused by others' attitudes, words, and behaviors. She still did not change her mind. She considered that earning a wage was more important than reduced stress, and so favored the vocational rehabilitation center. Therefore, I told her that if she eventually encountered the expected difficulties at the center, I was ready to support her in solving them. She had "expressed her choice" of the vocational rehabilitation center, the fourth competency ability [1], but later did not recognize her expression of that choice. She seemed to believe that she was coerced into attending the vocational rehabilitation center by me, an attitude incompatible with the definition of autonomy [2]. Since in her mind the responsibility for the initial decision was not her own, the subsequent consequences were not her responsibility.

I would next like to provide four interpretations as to why she did not acknowledge her decision. The first is that due to abandonment fear [12], she chose one of my recommendations via a "false self" [13,14] in order to fulfill what she perceived to be my expectation of her, a replication of the mother-daughter relationship dynamic that was to be

the hallmark of her interaction with me. In her subjective experience, her mother had never praised her, resulting in low self-esteem. From pre-adolescence, she was very sensitive to the comments of others. She pretended not to be wounded, but eventually refused to go to school. Unfulfilled desire for approval swelled, and was eventually transferred to the therapist (me). She acted the role of a desirable client, which made her unable to disagree with my recommendations. Her autonomic constraint was not external, but internal; in other words, her "internal object" (mother figure) [15] was projected upon me and she felt as if she was coerced by her therapist.

The second interpretation is that the patient's ego was partially supported by the therapist, as shown by reduced self-destructive behavior since having commenced psychotherapy. Winnicott [14] writes: "the ego of the infant is very strong, but only so because of the ego-support given by a good-enough mother who is able to throw her whole self into adapting to the needs of her infant". Ms. A's own ego was not integrated or independent because in her early life she had not sufficiently "introject[ed] the ego-supporting mother [16]" usually achieved by "ego-support from the mother [16]." If she had introjected, she would have been able to "keep alive the imago of the mother [in this instance, the therapist] in the inner world" until the next session, because "time is kept going by the mother, and this is one aspect of her auxiliary ego-functioning [17]." This lack of introjection made her relationships with significant others extremely shaky. Therefore, when I was absent from her between sessions, or when she felt the therapeutic relationship was insecure, the weakness of her own ego function manifested itself. When she perceived the therapeutic relationship as secure, she could use our sessions as a means by which to reflect upon what would benefit her future:

"In the future, my mother and father will die. Gradually, I want to become independent both economically and mentally. Also, I don't want to waste the effort I made at the vocational rehabilitation center. My parents do not take the long view of my future, they just think in the shorter term. When I complain about the center, my parents just tell me to quit. I am afraid I won't be able to get married, and even if I can, I am afraid I will get divorced in the future. So I have to look after myself."

However, when she felt she was not being supported by her therapist it was difficult for her to keep consistent aims and act on the basis of the "reality principle [18]." In this case, she was usually unable to take the long view and preferred actions that immediately alleviated painful experiences.

The third interpretation is also related to low ego function, more specifically, lack of ability to endure conflictive situations. She believed it was desirable to go to the vocational rehabilitation center, but on the other hand, she wanted to escape from its very stressful environment. The former desire derived from the "reality principle [18]", and the latter from the "pleasure principle [18]." She could not strike a balance between the two. As a result, she ascribed the idea of attendance to her therapist, and succumbed to the desire to alleviate all stresses. Thus, she believed that I coerced her into going to the vocational rehabilitation center, bringing about persecutory feelings and anger towards me. For her, this was less painful and more beneficial for maintaining her mental balance than enduring the conflict. This mechanism was evident when she perceived others' praise as negative. The negative evaluation was actually self-constructed. Perceiving others' praise as negative could perhaps be seen as a self-projection mechanism, as it allowed her to be proactive, by expressing anger and resentment, rather than dwelling on her self-perceived lack of worth, which would result in unbearable depressive mood.

The fourth interpretation is that she had an omnipotent expectation towards me, i.e., the expectation that therapy would solve life's problems, and so any negative life events after therapy were the fault of her therapist. This could be regarded as a reproduction of her relationship with her mother. Winnicott [19] writes that "the adaptive mother presents an object or a manipulation that meets the baby's needs, and so the baby begins to need just that which the mother presents. In this way the baby comes to feel confident in being able to create objects and to create the actual world." Through this process, "the infant can gradually abrogate omnipotence [13]." However, Ms. A had not had the "experience of omnipotence [19]" in the context of the relationship with her mother, and had been continuously harboring omnipotent expectations of her mother and various significant others, including the therapist. Almost all the negative outcomes related to pharmacotherapy as well as attendance at the vocational rehabilitation center were attributed to me. She seemed to have an expectation that I, as her therapist, should predict every negative event, based on my knowledge of her personality as well as the vocational center. Consequently, for her, negative experiences were due to her therapist's neglect, which again allowed her main reaction to be anger, although this time tinged with sadness. Although Ms. A's intelligence was within the normal range, and she suffered no hallucinations or delusions, Ms. A's competencies in decision making and exercising autonomy were, in my view, seriously impaired.

Case 2

Ms. B was 34 years old when she first visited me. The negative life events she experienced just before commencing psychotherapy were divorce and bankruptcy, due to the debts of her ex-husband, resulting in anxiety and depressive mood. She was a professional welfare worker. The nature of her decision-making capabilities could be identified throughout her life history, some of which I summarize below.

Life events immediately preceding the onset of psychological symptoms: I would like to describe briefly the causes of Ms. B's mental health breakdown, i.e., divorce and bankruptcy. She met her ex-husband through a mutual friend. Before marriage, he gave her many gifts and pushed her to marry him. Ms. B, without consideration of his divorce history, got married with him. She said, "my ex-husband decided our marriage arbitrarily." Gradually, his wasteful spending habits became evident. He spent a lot of money on his business (he managed a Japanese pub) as well as on his hobbies. Several times, he presented Ms. B with documents and requested her signature. In psychotherapy she said, "I did not know what they were but I just wrote my name as my ex-husband required of me." It is difficult to believe that she was not able to recognize those documents as loan guarantee forms, because she is an intelligent woman. Her ex-husband further required her to work at night as a bar hostess in addition to her daytime job as a welfare professional. Ms. B, although she did not want to work both day and night, started working at night because her ex-husband was also working at night and staying at home alone was unbearably lonely. When she was working at a pub as a hostess, she met a man known only as the "president," who invited her to have sexual relationships with customers for money. She was forbidden ever to talk about this work to anyone. Ms. B believed that of all the female workers in the club, she was the president's favorite. Because of this, she accepted his proposal; the source of the proposal completely overrode its illegality. She added this prostitution job to her daytime welfare work and evening hostessing. In addition to customers, she also had a sexual relationship with the "president." Due to lack of sleep, she made many mistakes during her day job and was disrespected and criticized by colleagues. She did not

take care of her physical condition. Eventually her husband discovered that she was engaging in prostitution, which resulted in divorce. After divorce she moved back in with her parents and declared bankruptcy.

At that point she started visiting the psychiatry hospital, her chief complaint being depressive mood and anxiety. At one point in the treatment process, she returned to her original job. Her performance as a professional was excellent, but her motivation was always external, i.e., the need for approval and admiration. On request, she undertook work outside her job description without complaint. She arrived at her workplace earlier than any other staff and cleaned there. When she did not receive her colleagues' gratitude, she said she felt disappointment and anger, never expressing these feelings but instead converting them into somatic symptoms often combined with absence from work. In my view these episodes demonstrate that she had no concept of agreeing or refusing based on self-deliberation and autonomous judgment. These attitudes seemed to be rooted in her childhood and adolescent life history, which I will describe below.

Life history: Ms. B was born in a rural area in Japan. When she was born, her parents, grandparents, and great-grandmother lived together. One year after her birth, her brother was born. As an infant she started living with her grandmother away from her parents' home. The reason for this separation from her parents remain murky, and to Ms. B unsatisfactory. During the night when her grandmother was working, she had to stay alone in one narrow dim room.

When she was six years old, she went back to her parents' house with her grandmother. Her mother seemed to be taking better care of her brother than of her. Furthermore, her brother was given precedence due to being male. Her brother fawned over his mother whereas Ms. B felt inhibited even though she desired a closer connection. Being competitive with her brother, Ms. B worked hard on her strong points in order to receive her mother's praise. Even when she achieved success, she never became self-confident, and only worked harder to fulfill her mother's high expectations. Although she harbored envy and hatred towards her brother, she once spontaneously took the blame when he broke something in the family home. Since elementary school she exhibited non-specific symptoms due to stress, possibly indicative of hypochondria. She initially disclosed these symptoms to her mother, and later reported them to me in therapy sessions. However, her mother did not notice that Ms. B sought her care and empathy and just admonished her to work harder. During junior high school, she was bullied by schoolmates, one of whom she believed to be her friend. At the end of the first grade, one popular male classmate became close to Ms. B, and the bullying drew to an end.

In senior high school, Ms. B tried to be liked by both bullies and the bullied. Eventually, she became isolated. In similar fashion to junior high school, she was comforted by a young man from her neighborhood. During senior high school, she harbored a feeling of envy towards a girl who was popular with her classmates. Ms. B made friends with her, intending to imitate all of her attractive feature with a view to ultimately surpassing her popularity. She neither considered nor planned her long-term future, because she was only concerned with entertaining classmates. At the end of the third grade, her teacher gave her this advice: "you are good at amusing others, so you should become a welfare worker," which she simply obeyed without any deliberate consideration.

She left her parents' house to enter a welfare vocational school. As she was not able to endure the loneliness she was experiencing, she stayed at a friend's home at night or invited her over. Her grandmother committed suicide when she was 18 years old. However, it was not until two years later that her father offhandedly told her of this. When she was 21 years old, she took a job as welfare professional and began living with a male colleague. She said he just brought his things to her apartment and began to cohabit. It sounded as if she had expressed no opinion at the time. To avoid being disliked by the man, she always focused on how she could please him. She believed that following his opinions would be the best way to be treated well. At some point, however, he said to Ms. B, "I cannot understand what you are thinking." On a surface level she always obeyed him, but behind his back, she had sexual relationships with several male friends, some of whom were his friends. She rationalized this behavior by telling herself she was not able to stay home alone when her boyfriend went out at night with his friends.

After five years, her boyfriend left Ms. B's apartment to marry a woman who was five years younger than Ms. B, and who Ms. B supervised at her workplace. Although this was an unbearably sad event for her, Ms. B did not express any negative feelings towards her boyfriend and still continued instructing his fiancée at work. Ms. B attributed the breakup to her appearance, so she began a diet and made an effort to improve her fashion sense. She swiftly attracted many men with whom she had sexual relationships. When the men expressed love for Ms. B, she rejected them arbitrarily. Her promiscuity became known in the neighborhood and her workplace. She then married her ex-husband so that she could leave the area, and she tried to forget her previous boyfriend.

Therapeutic relationship: Ms. B's way of relating to me was similar to the way she related to other people. For instance, when I recommended a weekly 45-minute psychotherapy session she gave the impression of agreeing. The psychotherapy passed smoothly. She responded readily to my interpretations, questions, and clarifications. However, her obedience to me plunged her into a dilemma, which I describe below.

Through the process of receiving psychotherapy, she was able to return to her job working near her parents' house. Her parents, who were addicted to gambling, counted on her salary, in particular her mother. She gave them money when asked. Ms. B complained that her mother used her as a bank. I advised her that it was a bad idea to give her money, because it would enable her addiction, and on the surface Ms. B seemed to have determined not to give her money anymore. However, I later found out that not only had she not stopped providing her with money, but she had also given her mother her cash card and PIN number. She encouraged her mother's addiction to fulfill her own needs momentarily, namely, to acquire her mother's gratitude and love.

I should also note the disruption of therapy due to the destructive impulses caused by the non-fulfillment of Ms. B's needs by her parents. In one session, she told me that she wanted to cancel the next therapy. Her professed reason was lack of money (the amount of the money she had to pay was about five dollars), because her parents used her money for gambling. In the session we met next, she confided that actually she had had the money, but her mother had said that it was inconvenient to drive Ms. B to my hospital on that day. She added that she actually could have driven herself. However, her mother's rejection stimulated her destructive behavior, in this instance directed at her in the form of not attending psychotherapy aimed to help her recover her well-being.

Interpretation: Under the DSM-IV system, this patient was diagnosed with "narcissistic personality disorder", "borderline personality disorder", and "dependent personality disorder". The

most useful concept to describe this patient is the "as if personality", a prototype proposed by Deutsch [11]. According to Deutsch, an individual with this personality prototype seems to be normal, and is "intellectually intact, gifted, and brings great understanding to intellectual and emotional problems." However, his/her personality pathology is severe: "any object will do as a bridge for identification." These individuals do not have a sound "ego-ideal [20]", and "their ideals, their convictions are simply reflections of another person [11]." Winnicott [13] noted that compared to the "as if personality", the "false self" presents itself better to the world. I propose the probable interpretation that Ms. A partially used the "false self" within the therapeutic relationship, whereas Ms. B's entire personality domain seemed to have been occupied by the "false self." Every effort made by Ms. B's "false self" for the purpose of eliciting her mother's approval only resulted in "a feeling unreal or a sense of futility [13]", which is compatible with the description of the "false self" by Winnicott [13,14] and the "as if personality" by Deutsch [11]. Winnicott [13] attributed the origin of the "false self" to the mother's failure to respond to the baby's spontaneous gestures expressed by the "true self", unavoidably plunging the baby into compliance, something enacted out repeatedly between Ms. B and any object. Furthermore, Ms. B had an omnipotent conviction that her compliance would enable her to control the object. If this conviction went unrealized, she took self-destructive measures and betrayed the object without any guilt, as Deutsch [11] suggested would occur in such cases. Due to the inconvenience her parents faced in driving her to the hospital, for instance, Ms. B readily canceled a psychotherapy session that would be expected to benefit her mental health.

Ms. B's grandmother, whom she regarded as her only caretaker, committed suicide, which fueled her desperate struggle to avoid losing any object. This was reflected in her passively compliant attitudes towards her boyfriend and the "president", as well as the facilitation of her mother's gambling addiction. Her promiscuous sexual relationships were rationalized by her intolerance for loneliness, which she had experienced repeatedly since infancy.

Another prominent defense mechanism frequently used by Ms. B was altruism [21]. The acts of taking care of her rivals, her brother, and the fiancée of her previous boyfriend, would fulfill this definition; she projected herself onto her rivals and cared desperately for them, the object of care actually being herself, the act of being cared for something she had never, in her mind, previously experienced. Another beneficial aspect of altruism is concealing the aggression felt towards the rivals.

To summarize, the reason why Ms. B simply left decisions on her personal matters to others can be explained as follows. Ms. B always thought that if she had her own opinions, in particular those that conflicted with those of others, she would come to be disliked and isolated. Intellectually, she could understand which decisions were desirable for her, but she avoided thinking, judging, and making decisions. Behind this was the momentary fulfillment of narcissistic needs, i.e., being superficially approved of by others, which in her case usually did not accord with moral principles. Thus, she did not have any concept of making decisions or exercising autonomy. One major contributing factor in her acquiescence to psychotherapy and the smooth interaction at a surface level with her therapist can be attributed to her personality pathology, and on a minor level, an expression of her reliance on the therapist.

General discussion: I discuss below the features common to the above two patients' from psychoanalytical viewpoints.

Ego function: Both patients' ego functions were weak. Both lacked to a serious degree the 12 ego functions proposed by Bellak [10], to which I referred in the introduction section. In particular, their conflict-free ego sphere [9], which is essential in establishing a therapeutic alliance [6,7] was seriously impaired. Ms. A's main purpose in coming for treatment was discharging her anger, rather than observing her intra-psychic world through the support of her therapist. In the case of Ms. B, she was preoccupied with obtaining her therapist's care and attention by establishing an accommodative relationship via the "false self [13,14]". In both cases, due to impaired ego function, their ability to make independent decisions was seriously deficient.

Tendency to seek futile pleasure and avoid transient pain: Both Ms. A and Ms. B were unable to endure experiences that brought them psychological pain, such as loneliness or lack of others' attention and care. They reacted to such experiences by acting out, for instance by binge eating, verbal attacks, promiscuity, and self-destructive or sometimes anti-social behavior. They could not process choices in terms of their long-term interests, and instead sought futile pleasure. In other words, they followed the "pleasure principle [18]" rather than the "reality principle [18]."

Seeking others' approval: Neither patient had the ability to maintain self-esteem through self-evaluation, which resulted in intense needs for approval and praise from others. The more intense the needs, the more frequently they experienced painful rejection caused by unmet needs, which in turn led to rage. These characteristics in relating to others could be attributed to the lack of satisfactory maternal care and attention. Both patients, in particular Ms. A, consequently needed others' opinions, detailed instructions, and thoughtful support concerning their circumstances. They had not established "a self, a unit that is both physically contained in the body's skin and that is psychologically integrated," and which is independent of the "mother's auxiliary ego [17]." They lacked the "capacity to be alone" [16] and had not "become able to enjoy solitude" as "a most precious possession [16]." Due to their lack of experience of a reliable mother as well as their intense need for others' support, they were always tortured by fears of abandonment and were constantly trying to read other people's faces. Eventually they were unable to concentrate on productive work. This was also observed in their therapeutic relationship with me, with Ms. B in particular. Her first priority was identifying with my expectations and playing the role of good patient with her "false self [13,14]", rather than exploring her intra-psychic world and deepening her self-understanding with my support.

Lack of guilt regarding their decisions and actions: Authentic concern and guilt were not observed in either patient's psyche. Winnicott [17] states that an infant's sense of guilt and concern are cultivated by an "environmental mother", whose role is "to continue to be herself, to be empathetic towards her infant, to be there to receive the spontaneous gesture, and to be pleased [17]", which provides her infant with the "opportunity for giving and for making reparation." Neither Ms. A nor Ms. B experienced an "environmental mother" to the extent they would have liked; they did not have either a sense of guilt relating to past anti-social behaviors, or any idea of how to modify their future conduct. For them, it would be extremely difficult to be responsible for their decisions and behaviors.

Cultural background and female patients' lack of ability to exercise autonomy: Compared to Western society, which regards autonomy as ideal, traditional Japanese society considered group harmony to be a virtue. It also required women to be passive and less assertive than men. Ms. B, who always used any person, idea, or culture

as an object of identification, partially accorded with the traditional Japanese culture insofar as she was in the presence of those who valued it. However, she is now working in a modern workplace, although she was raised in a rural area in Japan. In contemporary Japanese society, as in Western society, one is required to exercise autonomy of which Ms. B is incapable. Although Ms. A was raised in an urban area of Japan, where the general culture is much less traditional, and her parents put her brothers before her and ignored most of her appeals regarding sibling conflicts. Due to the traditional Japanese culture that regarded group harmony and passive women as virtues, there would be more risk in women exercising autonomy. When they enter modern society, which requires them to think, judge, and act as responsible persons, those incapable of fulfilling these requirements are prone to maladaptive states.

Application to Clinical Settings

Although respect for patient autonomy is essential in clinical bioethics, the granting of autonomy would be perceived by patients with pathological personality traits as an imposition due to their lack of self as a psychological unit. When required to exercise autonomy, they react with persecutory feelings based on the perception of being abandoned. Therapists should be alert to patients' spontaneous productive acts and praise them, taking on an environmental mother's role [17]. Furthermore, they should be prepared to help in decision making as well as take partial responsibility for the outcomes of their patients' actions. Only after repeatedly experiencing this process will patients come to establish an independent self.

Limitations

This study was based on only two clinical cases. Its results therefore cannot be applicable to every patient with personality disorders, in particular male patients.

Conclusion

In conclusion, I propose that the role of clinical psychiatry should not be limited to assessing and respecting patients' autonomy, but should be extended to nurturing autonomy by supporting patients' ego function.

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