

Case Report

Doing Psychiatry Right: A Case of Severe Avoidant Personality Disorder with Obsessive-compulsive Personality Disorder, Obsessive Compulsive Disorder, Intermittent Explosive Disorder and Sexual Paraphilias

Sudhir Hebbar

ABSTRACT

Over dependence on pharmacotherapy in psychiatry, known as biological imperialism, is a world-wide phenomenon. Some authors have opined that the inadequate and ineffective utilization of psychotherapeutic interventions and only dependence on pharmacotherapy amounts to institutional malpractice. Here is an example of such a case. A young male mainly received multiple psychotropic medicines, including clozapine (and also a failed psychotherapy) over a period of 4 years, without any benefit. His global assessment of function score remained at 30. However, with proper diagnosis and effectively conducted psychotherapy a significant improvement in Global assessment of functioning score of 70 was achieved, over a period of 1½ years.

Key words: *Autogynephilia, avoidant personality, cognitive therapy, intermittent explosive disorder*

INTRODUCTION

In a book titled “doing psychiatry wrong”^[1] the author (a Psychiatrist) describes several cases treated with medications, mostly inappropriately (e.g., patient with borderline personality treated as bipolar disorder, multi drug abuser treated as schizophrenia), without much gain. He claims that such mismanagement is quite common. Another author^[2] (a Sociologist) argues that

in spite of the evidence that psychiatric conditions improve best with a combination of medicines and therapy, psychotherapy is rarely offered. This trend is referred by the author as an institutional malpractice. That author’s research has shown that such patients who were treated only with medicines “do less well, are readmitted more quickly, diagnosed more inaccurately and medicated more randomly.” Here is a case report, which endorses all these aspects. This case was inaccurately diagnosed, randomly medicated and did less well. Properly conducted psychotherapy has improved the patient. Are we in to a second wave of anti-psychiatry movement against biological imperialism?

CASE REPORT

A 23-year-old male, B.E student from upper middle socio-economic status, accompanied by his parents,

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Department of Psychiatry, Rajarajeswari Medical College, Bengaluru, Karnataka, India

Address for correspondence: Dr. Sudhir Hebbar

Department of Psychiatry, Rajarajeswari Medical College, Bengaluru, Karnataka, India. E-mail: drsudhirhebbar@gmail.com

presented with the complaints of anger outbursts, inability to mingle with people and inability to study. Insidiously symptoms started over a period of 4 years and gradually worsened. For the past 2 years, he attended neither the classes nor the home tuitions. He could not clear 15 papers. Most of the activities, which he tried to do ended in failure and angry frustrations. Most of the time was spent in sleep, which was aided by sedative psychotropic medicines. He could not tolerate inactivity as it led to boredom and this was intolerable. Remaining small time in the day he displayed a “typical pattern” of behavior as noted by Pedesky and Beck^[3] “they may discontinue a task or fail to initiate a task they had planned to do. They may turn on the television, pick up some things to read, reach for food or a cigarette, get up and walk around and henceforth.” He was more or less home bound. Neither patient nor his parents could explain his anger and other symptoms. Mental status of the patient was that of an inhibited plump person with expressionless serious face, answering questions minimally, but relevantly without any psychotic symptoms.

Most of his anger outbursts erupted and lasted only for a few seconds and a few are followed by grumbling and shouting for about 10 min. Anger resulted in yelling with angry gestures, banging, crumpling, throwing, tearing and breaking of objects (one per attack) such as shirt, pen, pencils, spectacles, remote control and rarely, mobile phones or computers. Anger was followed by remorse. These outbursts were not expressed in front of others as it was shameful. Daily there were countless yelling and at least 2 tares or breaks. His father had become an expert at fixing the spectacles.

He avoided close relatives, strangers and crowds as it induced severe fear and inhibition. He was scared to talk to house maid, lift operator in the apartment, traffic police and ladies. He avoided ladies just like how people avoid a cobra. He looked away from them and walked away at the prospect of an approaching lady. He avoided almost all activities outside home.

He had several other fears and phobias. He feared contamination with its health hazards. In fact his first visit to a Psychiatrist was due to fear of Lead contamination from wall paints. He was scared of black magic and masturbation and wanted to control it. His other fears were, being cursed by god, old and sick people if they are disturbed by mistake, fear of going deaf or blind by strong sounds or bright light. He had magical beliefs that bad words if heard in the early morning, they will spoil the whole day and if any bad word is heard while praying, god will curse. All these beliefs were the sources of his frustration and resulted in anger.

He had rigid moral values in the matters of sexuality, religion and right or wrongs. He got infuriated with matters such as Muslim religion, female gender, Britons, beef eaters and rule breakers. He was pre-occupied with his sagging chest and wore tight banyans to hide it. He wanted to have a perfect body. His fantasy was to become a business tycoon or a Scientist. During masturbation, frequently he had fantasy of sadomasochism, transvestic fetishism and autogynephilia.

His inability to study was the result of several factors. He wanted to understand the subject perfectly and this inability led to a sense of failure and frustration and anger. He wanted to exactly reproduce the figures and examples given in the text book. He gave importance to learning by rote memory. Prospect of understanding led to an excitement and he could not focus. Frustrated, anxious and angry mental set also took away his focus.

Patient was born to a highly educated and well-employed couple hailing from upper socio-economic status. His first degree paternal uncle has a chronic psychotic illness, but he is too highly educated and regularly employed. There was no marital conflict between the parents. They do not appear to have any significant personality disorders and are physically healthy. There was no history of child abuse at home. He has one healthy sister. As a child he was quite sweet and was socializing reasonably well. However, he was noted to be angry and used to kick walls if he got angry. In 10th and 11th standard he was bullied frequently by few students and ridiculed for his sagging chest by touching it. Patient remained un-assertive and the abuse and emotional trauma inflicted was significant. During adolescence his inter personal problems started appearing. He deliberately failed in one subject, just because a teacher had insulted him. His past psychological assessments revealed above average intelligence and presence of several personalities disorder traits and low self-esteem.

He was treated by more than a dozen of Psychiatrist, exhausting all psychotropic medicines, including clozapine at 200 mg/day. He underwent psychotherapy for 1 year from a well-qualified Psychologist. None of these led to any improvement. When he visited the author he was on lithium 400 mg, fluoxetine 60 mg, amisulpride 100 mg, quetiapine 50 mg, clonazepam 3 mg, pregabalin 300 mg. He had undergone several Magico-Religious treatments. His global assessment of function at the time of presentation was at 30.

TREATMENT AND OUTCOME

Cognitive therapy espoused by Pedesky and Beck^[3-6] was administered over 1½ years, weekly 1-2 sessions

of 1-2 h duration. Patient was educated about the disadvantages of cognitive avoidance and encouraged to abandon it. Schema modifications, behavioral experiments, cognitive restructuring, brief repeated exposures (real and imaginary), exposure and/or response prevention for obsessional symptoms were used during therapy. Trauma of being bullied required only cognitive restructuring. Experiential techniques were not used. Dichotomous thinking was repeatedly corrected. Medications were tapered to sertraline 50 mg and aripiprazole 10 mg. He cleared 15 failed papers and is now attending his regular classes. Anger outbursts reduced to one tear or break per week. Socialization and ability to study individually improved. His current global assessment of functioning is at 70.

DISCUSSION

Psychiatrist trained to diagnose patients using atheoretical diagnostic systems and to treat by medicines is likely to over diagnose a psychotic illness in this case and treat accordingly. A flat affect, minimal talk, inhibited appearance, apparently unexplained anger outbursts and psychotic illness in a family member can lead to a misdiagnosis. A closer look reveals his warm affect, a keen interest to socialize and reasons for his anger. In fact historically this patient might have diagnosed as pseudo-neurotic schizophrenia,^[7,8] because of pervasive fears, phobias and strange sexual fantasies. In the past, severe avoidant cases were clubbed with schizoid personality. Knowledge of cognitive theory and therapy helped the author to arrive at a right understanding (diagnosis) of the patient and consequently the proper treatment. Patient warrants an additional diagnosis of intermittent explosive disorder because aggression is not a part of avoidant personality. Patient expressed anger indirectly by destroying objects. He also had anankastic personality disorder, obsessive-compulsive disorder, body dysmorphic disorder and paraphilia and even a Dhat syndrome.

Patient's anger was explainable when closely analyzed. One of the foundations of cognitive theory and therapy is that the appraisal (personal meaning given) of the events results in the emotions. Being a perfectionist, his

failure in daily activities resulted in anger. Being a rigid rule follower, violation of rules led to violent anger. He saw insults and cheatings where there were none, which resulted in anger. Over-concern with contamination and many other fears made him frustrated and angry. Similarly, his social fear can be explained by extreme sense of shame, sensitivity to insult and appraisal of people as dangerous and "paranoid" (patient's own word) about him. The "typical pattern" of behavior noted earlier, can be explained by the cognitive and emotional avoidances. Patient was intolerant of dysphoria and to reduce it, he repeatedly attempted to do one or the other activity.

This case proves that psychotherapy can be a mainstay of treatment even in severe personality disorders. Psychotherapy can work even in mainly biologically caused conditions by changing biology itself. There is wisdom in the saying "psychology ultimately expresses through biology."

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