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Opinion

A Penitent Psychiatrist

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Review

A young man, in his early adulthood, was referred to a psychiatric facility due to his overwhelming nervousness and touchiness, which began in his early adolescence. Since he was not, essentially, interested in any psychiatric interview and did not appear in the introductory meeting, his mom addressed some preliminary data regarding his development, education, and societal and personal history. Indeed, she was insisting on his psychiatric probe. Anyhow, as stated by her, though he was a college student, he did not have any close friends, romantic history, warm communication with his classmates, or energetic participation in group activities. Likewise, his interaction with his siblings, parents, or relatives was not nice or kind. Since his childhood, in comparison with his siblings, he was noticeably more uneasy and short-tempered. But, while she could remember his unusual worriedness during common journeys, plus some irritation or sleep problems in unaccustomed places, no solid criteria of neurodevelopmental disorders, including intellectual disabilities, communication disorders, autism spectrum disorder, attention-deficit/hyperactivity disorder, specific learning disorder, or motor disorders, were evident. Likewise, though there was no specific problem regarding his youthful interactions with siblings, playmates, or classmates, and there was not any specific disciplinary, habitual, or criminal history during his adolescence and young adulthood, the absence of closeness or warmness in his interpersonal communications was not deniable. As an apprentice, he had not failed any semester up till then and was going to finish his college education soon. On the word of his mom, he was a believer and devoted to current moral values and principles. As said before, since his mom was worried regarding her son's social isolation, anxiety, and bad temper, she had asked the primary care physician to refer him for a psychiatric appraisal. Anyway, after a few days, the patient, in the company of his mom, went to see the psychiatrist. In spite of his unwillingness, his social contact and greeting were okay. But this slender, good-looking, and smart guy, who looked obviously restless and fearful, was trying vainly to hide his tenseness, which was reverberating manifestly in his speech and expression. Eventually, his semi-cooperative attitude, bit by bit, turned into a cooperative approach, which helped the psychiatrist to delve better into his inner feelings and subjective assumptions. On the other hand, neither he nor his mom could identify a clear distinction between his current morbid condition and his premorbid period. When he was asked which factor, finally, convinced him to come to see the doctor, he replied that maybe suppression of assertiveness and inhibition of social participation by the present condition, which had hassled him so long, could be accounted for as a pivotal reason. As said by him, his academic achievements, too, were mostly around theoretical issues, while his social activities were heavily impacted due to his ceaseless tension. Though many times he could find some excuses for avoiding classes, workshops, or outside activities, it had undermined, manifestly, his credits or esteem. He was feeling like a balloon that could not be bloated enough for flying. In further exploration it became evident that, in fact, he had been suffering from recurrent panic attacks in the last few years, which had caused him to avoid, in general, crowded, closed spaces and unfamiliar places and to appeal frequently, but not always, for accompaniment by one of his relatives for out-of-doors goings-on. Indeed, in the last few months, he could not leave home without difficulty or alone. Also, though the course of tension was not without constant fluctuations, recently it has become more severe and distressing, which caused him to cancel his last two college semesters. Thus, he was on the verge of rustication or suspension as well. Accordingly, based on the available data and mental status examination, he was diagnosed as a case of panic disorder with agoraphobia and was prescribed sertraline, 50 mg per day, which increased gradually to 100 mg daily, plus clonazepam, 0.25-0.50 mg nightly, before bedtime. A few weeks later, while he had improved profoundly, he recommenced his college. His follow-up, as well, during the next few months was okay. After six months, when he was asked to be ready for tapering the dosage, he negated the plan and requested his psychiatrist to continue that dosage for a longer time because his surroundings were too nerve-racking, and he was afraid that the said maneuver might ruin his accomplishments. Consequently, his doctor reviewed the protocol and decided to continue the said medication for a longer period. Then after a while, his mother, who had not accompanied him except for the first session, came to the clinic to talk with the doctor. As stated by her, though his son's apprehension was improved prominently, another problem started afterwards, which included his limitless greediness, or self-centeredness. For example, though his parents were still alive, he had asked them for his inheritance in cash, or while they were living with each other in a shared family home, he expected a bigger room, better cuisine, or more reverence—expectations that were not obvious before and were not common in a traditional family. As said by her, his egotistical expectations, which started immediately after the disappearance of his morbid trepidation, were so shocking and agonizing for his parents and siblings that their domestic milieu had become, more or less, unbalanced and distressed; allegations, which had been approved later by the patient as well, though with lots of rationalizations, distortions, and partiality. As said by him, those problems were a series of correctable difficulties that he could not address before suitably because he had not had enough time or motivation to do that, and he did not care about values that did not, reciprocally, care about him. He believed that, based on his general or

academic info, he was legitimately right, and his family did not want to take that. At first, the psychiatrist supposed that perhaps it was a medication-induced disinhibition, which could be prevented by a more gradual increase in dosage. But, since he was a firstborn child, and his developmental history as well could indicate an extra interest with respect to this spoiled baby in the household, the formulation of the recent alterations around a narcissistic trait or personality, which could not express itself enough until that time due to the existence of a primary anxiety disorder, did not seem implausible. On the other hand, his present self-centered anticipations were not accompanied with risky conduct or interactions in social or academic surroundings. Likewise, his preceding sick role could have recompensed somewhat his egotistic predisposition by instinctive provocation of others' sympathy or abnegation. His mother approved that during his babyhood, as well, in comparison with his siblings, he was not devoid of self-regarding stances, though with childish features. Anyhow, during the next few months, the said rising conflict continued, and follow-up of panic disorder, as a primary psychiatric disorder, turned into follow-up of relational problems, as 'other conditions that may be a focus of clinical attention.' Eventually, the aforesaid condition turned out to be so serious that his psychiatrist became really repentant respecting his earlier successful treatment for his panic disorder. In this regard, though he was morally devoted to helping help-seekers, a duty that had been performed fruitfully, he thought, discreetly, that maybe, in contrast to psychoses or affective disorders, where a patient is managed for saving, representationally, a family (along with himself), in this instance, if he would not treat the patient, he could save a family. Such kind of conflict in a therapist, namely, between duty and outcome, may not be rare with respect to management of primary psychiatric disorders in persons with morbid syndromes, like personality disorders. On the whole, whereas personality disorder symptoms are ego-syntonic (i.e., acceptable to the ego, as opposed to ego-dystonic) and alloplastic (i.e., adapt by trying to alter the external environment rather than themselves), persons with personality disorders do not feel worry about their maladaptive behavior. For the reason that they do not routinely acknowledge pain from what others perceive as their symptoms, they often seem disinterested in treatment and resistant to recovery. On the other hand, although established personality traits are fairly stable, they may be exacerbated in the short term by stress ('DE compensation'). On the other hand, while mature personality disorders are first recognizable in late adolescence and remain stable or worsen with age, immature personality disorders (like our patient) have an onset in childhood and may mellow with age. In general, personality disorder may predispose to psychiatric disorder or may coexist with psychiatric disorder and worsen prognosis. Also, while it can be mistaken for a psychiatric disorder, it can be affected by a psychiatric disorder and may have a pathoplastic effect on a psychiatric disorder (that is to say, it may modify the clinical features even if it has no direct causal role). In the same way, psychiatric disorders may affect how personality is expressed. In a few words, it is not deniable that comorbidity of personality disorder with primary psychiatric disorder may be the worst nightmare for any psychiatrist who tries to accomplish his responsibility scrupulously and spotlessly [1-10].

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