doi.org/10.51891/rease.v10i7.14850

THERAPEUTIC APPROACH IN COEXISTENCE OF AVOIDANT PERSONALITY DISORDER AND PSYCHOTIC STRUCTURE IN ITS EARLY MANIFESTATIONS: A CASE REPORT

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ABSTRACT: **Introduction:** The first manifestations of a psychotic structure, generally in adolescence or early adulthood, are an important milestone in an individual's life. But, considering the concomitant signs and symptoms of an avoidant personality disorder can appear since childhood, there is a demand for more targeted and delicate attention from the team of healthcare professionals. **Case summary:** During the monitoring of the patient, a series of clinical signs and symptoms appeared that met the criteria of two simultaneous psychic conditions, one of them structural and the other personality related. With the aforementioned diagnoses, specific new pharmacological treatment tests were carried out, carrying positive effects and improving the patient's quality of life (introduction of antipsychotics instead of antidepressants as the pivot of therapy). **Discussion:** the onset of a psychotic condition in the *trema* phase associated with pre-existing avoidant/avoidant personality disorder demands balanced management between both conditions, using the strategies offered by both pharmacotherapies and psychotherapies. **Conclusion:** in order to adopt an appropriate treatment and management of the case, due to the complexity of diagnostic simultaneity, constant attention is required from the assistant team, so that continuous reassessments of hypotheses are made and, therefore, adjustments whenever necessary.

Keywords: Psychoanalysis. Antipsychotic Agents. Psychopathology.

RESUMO: **Introdução**: As primeiras manifestações de uma estrutura psicótica, geralmente na adolescência ou início da vida adulta, representam um marco importante na vida de um indivíduo. Contudo, considerando que os sinais e sintomas concomitantes de um transtorno de personalidade evitativa podem surgir desde a infância, há uma demanda por atenção mais direcionada e delicada por parte da equipe de profissionais de saúde. **Sumário do caso**: Durante o acompanhamento do paciente, uma série de sinais e sintomas clínicos atenderam aos critérios de duas condições psíquicas simultâneas, uma estrutural e outra relacionada à personalidade. Com os diagnósticos mencionados, foram realizados novos testes específicos de tratamento farmacológico, com efeitos positivos e melhoria na qualidade de vida do paciente (introdução de antipsicóticos em vez de antidepressivos como pivô da terapia). **Discussão**: O início de uma condição psicótica na fase trema associada ao transtorno de personalidade evitativa pré-existente demanda um manejo equilibrado entre ambas as condições, utilizando as estratégias oferecidas tanto pela farmacoterapia quanto pela psicoterapia. **Conclusão**: Para adotar um tratamento e manejo adequados do caso, devido à complexidade da simultaneidade diagnóstica, é necessária atenção constante da equipe assistente, garantindo reavaliações contínuas das hipóteses e, consequentemente, ajustes sempre que necessário.

Palavras-chave: Psicanálise. Agentes Antipsicóticos. Psicopatologia.

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INTRODUCTION

Psychotic disorders are a group of mental illnesses that can be identified by a specific symptom such as schizophreniform disorder, schizoaffective disorder, delusional disorder, brief psychotic disorder, shared psychotic disorder, psychotic disorder due to a known physical condition, substance-induced psychotic disorder and schizophrenia[1]. However, psychotic symptoms can also manifest in other spectrums, such as dementia, mood disorders and personality disorders[2].

Personality disorders are, in general, related to psychological development and their diagnosis should not be formulated before adulthood due to the plasticity of personality during childhood and adolescence[3]. According to the definition found by authors in the Brazilian book Compêndio de Clínica Psiquiátrica, a psychological disorder associated with personality is "a persistent pattern of intimate experience and behavior that deviates markedly from the expectations of the individual's culture, is pervasive and inflexible, begins in adolescence or early adulthood, is stable over time and causes suffering or harm, and manifests itself in at least two of the following areas: cognition, affectivity, interpersonal functioning or impulse control"[4].

As for the diagnosis of schizophrenia, also according to the DSM-5, two or more of the following symptoms must be observed: delusional ideas, hallucinations or disorganized language, catatonic or disorganized behavior and negative symptoms - the presence of at least one of the first three being mandatory[1].

This case report describes a diagnosis that ranges from avoidant personality disorder to schizophrenia in its early stages of manifestation. Challenging the scarcity of literature on the management of the two associated comorbidities, the case demonstrates therapeutic success and may reveal a new approach when the two conditions coexist.

Case report

Patient M.E.M.S. was admitted to our primary health care unit in March 2022 complaining about anxiety, extreme discouragement and "lack of self-confidence", with a prescription of Venlafaxine 75 mg by the doctor previously responsible for the case. The patient reported that the medication was being used correctly. He was born and had lived part of his childhood in Campinas, (SP), later moving to the city of Contagem (MG) with

his family, where he currently lives. He had no previous history of clearly diagnosed psychiatric disorders. He reported normal psychomotor development, without the need for any medical intervention.

The patient said his mother was being treated for bipolar affective disorder and was unaware of any paternal psychiatric disorders. The patient had an older brother, with whom he got along well. M.E.M.S. described a precarious family relationship, filled with aggressions and emotional distancing. He worked most of the time as a bricklayer, but also worked various informal jobs to supplement his monthly income. He started smoking at the age of 20 and, since then, consumed about 20 cigarettes/day. He mentioned a sporadic use of alcoholic beverages and no use of any other substances.

Regarding his childhood, the patient described himself as being an introverted child with a lack of ability to initiate contact with others, even if he wanted to. He said that he spent most of his childhood at home, justifying that his father did not allow him to go out. He abandoned his studies in the 3rd grade of primary school, claiming difficulties in maintaining attendance because he used to travel frequently between Campinas and Contagem with his parents. At the time, he hoped to complete his school degree to be able to go to college. During his adolescence, he went through many conflicts with his mother, and then, at the age of 20, took the decision to leave home and live as a homeless person. The patient remained in this situation for about a month and preferred not to comment about his experience during this period, stating that "I saw and experienced terrible things".

M.E.M.S. said that he had lived three romantic relationships, however none of those were continued. He emphasized about the last relationship, in which he was threatened with a firearm by the girl's father, triggering his first and only episode of suicidal intent, by ingesting a significant amount of an energy drink. He reported having difficulty dealing with his feelings, describing intense emotion when he felt in love, in which "he only thought about the person" and associated this difficulty with the discontinuation of his studies, because "he ended up not learning this subject at school". He mentioned having no friends and said that he could only maintain dialogue through online games, but even then he said he felt " strange" when talking to others.

In May 2022, M.E.M.S. said that he was feeling extremely undervalued and pressured in his work, culminating in a "stress attack", leading him to destroy all the objects

around him, leaving the place in a hurry and ending up losing his job. Since that episode, he had difficulty in carrying out his activities, saying "something that would take me two hours to do, today I need one whole day, because I get stuck and then I can't do anything else, or I do it slowly". In July of the same year, he began to have difficulties leaving his house, going out exclusively to do informal jobs, since those were his only remaining source of income. In August, the patient described that he felt as "an outsider in society" and that he was "falling into a hole", recognizing that his condition was progressively getting worse. He mentioned his feeling of not being welcomed by anyone, except his dog, Bob. "I felt like I fell into this world by parachute". Treatment of Risperidone 1 mg/night was initiated.

After two weeks, M.E.M.S. reported feeling "horrible, even more anxious." He associated the increasing anxiety with the difficulty of paying his bills due to not having a formal job. The patient said that "bad thoughts" had intensified, which had led to several instances of suicidal ideation. The team explained the role and potential of the Psychosocial Care Centers (CAPS) and the Social Assistance Reference Center (CRAS), to help him meet his basic needs and follow-up with the Risperidone treatment, combined with Cognitive Behavioural Therapy (CBT). After a week, M.E.M.S. said he was feeling "better and calmer". After 5 months of follow-up, there was a substantial improvement in his complaints and a slow return to work.

Discussion

Considering that the case reported is an avoidant personality disorder concomitant with the development of a psychotic condition, possibly schizophrenia, we will analyze the correlation between these two pathologies, especially in young men.

Taking into account the patient's age (25), along with his reports about his past and his development, it is clear that the patient already presented personality characteristics during his growth that correspond to an Avoidant Personality Disorder (AvPD). AvPD is described as “Social inhibition, feelings of inadequacy, and hypersensitivity to negative evaluation”[5]. It is important to emphasize that interpersonal contact is desired, but feared[6], and several times the patient mentioned the wish of starting a conversation and/or remaining in it, but that he felt like a "ghost" and described not knowing how to talk to people. Figure 1 summarizes the criteria for diagnosing AvPD according to the DSM-V.

Figure 1: Criteria for Avoidant Personality Disorder according to the DSM-V.

Avoidant Personality Disorder – Diagnostic Criteria
A pervasive pattern of social inhibition, feelings of inadequacy, and hypersensitivity to negative evaluation, beginning by early adulthood and present in a variety of contexts, as indicated by four (or more) of the following: Avoids occupational activities that involve significant interpersonal contact because of fears of criticism, disapproval, or rejection. Is unwilling to get involved with people unless certain og being liked. Shows restraint within intimate relationships because of the fear of being shamed or ridiculed. Is preoccupied with being criticizes or rejected in social situations. Is inhibited in new interpersonal situations because of feelings of inadequacy. Views self as socially inept, personally unappealing, or inferior to others. Is unusually reluctant to take personal risks or to engage in any new activities because they may prove embarrassing.

As the patient was apparently moving towards the triggering of a psychotic structure, especially considering his report of the two previous crises, it is important to analyze the correlation between his current condition - AvPD - and schizophrenia, as it is considered the main form of psychosis, given its prevalence and clinical importance[3]. In men, there is a peak incidence of schizophrenia between the early and mid-20s, which is observed later in women[2,7].

Few studies have focused on the association between personality disorders and psychosis[8,9], however after analyzing the existing research, we can see that the results are complex. Hogg *et al.*[10] analyzed 40 inpatients with schizophrenia and found that 30% of their sample (n = 12) had some disorder and 28% (n = 11) had a combination of multiple personality disorders, with avoidance being 10% of them (n = 4). Solano and de Chavez[11] also analyzed 40 schizophrenia outpatients and reported that 33% of these patients had AvPD prior to schizophrenia (n = 13), which was the most prevalent, followed by 11 schizoid (28%) and eight paranoid and dependent (20%) in the sample. In contrast, in a study carried out in 2005

by Keshavan *et al*[12], with a sample of 63 patients, the most frequent were paranoid (n = 18, 29%), schizotypal (n = 15, 24%) and, finally, avoidant (n = 12, 19%). The latest study analyzing the presence of a personality disorder in the first psychotic episode, published in 2008 by Simonsen *et al*[8], reveals that of the 33 patients in the study, 22 had criteria for one or more personality disorders (69%), according to the SCID-II (Structured Clinical Interview for DSM-IV-TR Axis II Personality Disorders), 34% of whom had SPD. The same study also used the MCMI-II (The Millon Clinical Multiaxial Inventory-II), showing an even higher percentage of AvPD prior to schizophrenia (38%, n = 12). Therefore, psychosis is associated with personality disorders, and for a significant part, it can be a=AvPd with schizophrenia.

As the patient does not fit the actual diagnosis of schizophrenia established by the DSM-V, which mandatorily includes at least one of the criteria of delusional ideas, hallucinations or disorganized[1], we can then introduce the idea of what is called "incipient schizophrenia"[13].

This term was coined by Klaus Conrad, who had followed, for years, the structuration and evolution of schizophrenic outbreaks. According to the author, the schizophrenic outbreak goes through several phases: *Trema, Apophenia, Apocalypse, Consolidation Phase* and *Residual Phase*. We will focus here on the first phase, the *Trema*. As defined by Klaus, in this phase "The patient manifestly experiences that abyss that separates him from others; experience of not being able to go alongside them, being excluded. He notes with sadness that he has lost the possibility of "us", the feeling of belonging to the group. In a terrible way, he is banished to his own world"[13]. We can say that the psychic space is surrounded by barriers, as if it was narrowed, leading the individual to feel rejected in a world of his own, creating an abyss[13]. This phase can be perceived and felt by each person differently, as it varies according to the subject's previous personality, feeling anguish, pressure or tension, restlessness, animation, joy etc - which also determines the theme of the delusions.

The correlations between some of the patient's accounts and Conrad's definition make it hard to doubt that M.E.M.S was in this first stage: "I do not know why I am in this world", "I am an outsider in society" "I feel like a ghost". When these barriers finally

disappear, the subject feels free, thus ending the Trema, setting the stage to what was already being announced by the growing tension: the delusions.

Considering personality disorders as premorbid in schizophrenia corroborates the hypothesis of some authors on the neurodevelopment of this psychopathology. In short, it argues that this disorder of psychotic nature arises as an early and non-progressive brain injury, but before actually manifesting itself as schizophrenia, it would appear in a more subtle way, as personality disorders[14,15,16].

As shown in the case, the patient was treated with venlafaxine 75mg daily in monotherapy for approximately 6 months, with no positive results reported. Throughout the report, we can observe a worsening of the AvPD, leading to a psychotic onset. The presence of a premorbid personality disorder in schizophrenia can have even more significant effects on the course of the illness, as has also been observed in other mental disorders[9]. Currently, there is no empirical evidence to guide the treatment of AvPD comorbid with schizophrenia[9], so we will focus on the therapeutic association of the two pathologies. Few studies focus on therapy for AvPD exclusively, but we know that psychotherapy is the main primary treatment for personality disorders[6, 17, 18, 19], from behavioral therapy to psychoanalysis[17]. There is also no evidence to guide the therapy of the prodromal phase of schizophrenia, but it is certain that episodes of stress, whether psychotic or not, are a factor in the exacerbation and negative perpetuation of mental disorders[20].

As treatment with antidepressants wasn't effective, we opted for a combination of antipsychotics (risperidone 2g/day) and cognitive behavioral therapy, which showed good results that could be observed in subsequent consultations and even reported by the patient.

CONCLUSION

The concomitance of an avoidant personality disorder leading to the first psychotic episode can prove to be a challenge for the healthcare team in terms of diagnosis and behavior. For this reason, it is up to the professionals' attentiveness to the nuances that can be show up during the Mental State Examination (MSE), the search for previous clinical and personal history, the patient's relationship with the service and the environment in which they live, be it their home, their workplace or with their family. This monitoring should be done longitudinally and constantly reviewed in view of the various interventions

that can be taken, bearing in mind the need for constant diagnostic, medication and condition management revision. In this case, a significant clinical improvement was seen with the pharmacological adjustment from an antidepressant to an antipsychotic associated with Cognitive Behavioural Therapy. We emphasize the importance of clinical studies demonstrating the effectiveness of therapy when personality disorders are associated with psychotic conditions.

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