



by Professor Gordon Parker

# mind over matter

## Extreme distress

Inappropriate therapy unmasks severe underlying anxiety and guilt.

### HISTORY

OSCAR, 43, was referred by his exasperated GP (“he wants a second opinion, but I think it’s his sixth”), more for management recommendations for his “personality disorder” than for diagnostic clarification.

Previous psychiatric assessments had generated alternative diagnoses of dysthymia, anxious depression and alcoholism, while a number of interventions had been tried in recent years.

Oscar had many strengths. Married for 20 years and with a good relationship with his three adolescent children, he held a responsible position in an accountancy firm.

He had experienced episodic depressive episodes since adolescence, but his depression had become persistent and disabling over the previous three years.

Oscar had recently received a retrenchment offer. Over this same period, he described extreme anxiety, relieved by cutting his arms and (at times) his torso in savage bursts.

He was currently on two antidepressants (at higher than recommended doses), took 50-100 mg of diazepam a day, and occasionally drank a bottle of vodka over a two-hour period, whereas he had rarely drunk in the past.

### DIAGNOSTIC QUESTION

At first pass, the history did not compute.

Oscar had been a meticulous and respected worker for nearly two decades in the same company. His relationship with his wife had been good until the

previous three years, and his children still respected him.

Such features disallowed diagnosis of a personality disorder.

### CLARIFICATION

At interview, Oscar showed evidence of distinct psychomotor agitation.

His behaviour was compatible more with an agitated melancholic depression than an anxiety state or even benzodiazepine withdrawal.

History identified symptoms supportive of a melancholic depressive sub-type (profound anhedonia, appetite and weight loss, concentration impairment, and diurnal variation of mood and energy).

Oscar described – as he had previously to several doctors – being sexually abused by his uncle for several years as an adolescent.

However, it appeared he probably experienced true episodes of melancholic depression since his mid-30s, which had

**A ‘lock’ had been created, and the therapist had provided a ‘key’**

worsened over the most recent five years.

While melancholic depression can be associated with suicidal ideation, Oscar’s extreme self-injurious behaviour was uncharacteristic.

Events coinciding with the onset of his extreme self-harm behaviours were pursued. It was noted he had recently stopped therapy with a psychotherapist – who he had been seeing three times a week.

The nature of the psychotherapy was questioned. The



The patient’s extreme self-injurious behaviour was not consistent with his melancholic depression.

therapist had encouraged Oscar to believe that “love conquered all”, and was constantly positive and reassuring.

Oscar was pressed as to why he had left therapy.

Had there been any boundary violation? No. Was there any physical contact? Yes, the therapist would always put his arm around Oscar at the beginning and end of each session, and several times had hugged him warmly as Oscar had left.

Further pressed about what such physical expressions meant to him, Oscar admitted that he had, over the first few months of therapy, begun to question his sexuality.

He became attracted emotionally to his charismatic therapist and progressively impotent with his wife. He wondered whether he was attracted sexually to his therapist.

Such emotions generated

extreme guilt, distress and panic attacks, leading to his self-harming behaviours.

His responses to his earlier sexual abuse were gently explored.

For most of the four-year period he had been ashamed and often terrified, but he remembered a later time when he had actually felt attracted and warm towards his abusive uncle.

That reaction had caused him great shame.

However, Oscar’s marriage, career, and children had all allowed him to suppress much of his emotional distress.

### FORMULATION

Oscar’s story illustrates the multi-layering of distress experienced by many individuals.

Oscar certainly had a previously unrecognised melancholic depression that had not received

potentially effective treatments, but there was more to the story.

Over the three preceding years, the therapist had reactivated a distress that had originally developed in Oscar’s adolescence.

The sexual abuse had been traumatic, but Oscar had suppressed its effects.

Inappropriate behaviour by the therapist had, however, unleashed in Oscar an intolerable flood of guilt about his sexual orientation.

At that early vulnerable time, a ‘lock’ had been created, and the therapist effectively provided a ‘key’ by his boundary violations of touching and inappropriate intimacy.

Once appropriate medication had improved his melancholia, Oscar would need quite sophisticated counselling to redress the boundary-induced damage.

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