Therapeutic assessment as a brief and intensive intervention for avoidant restrictive food intake disorder, belching, and histrionic personality disorder: A case report

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ABSTRACT

A 26-year-old female was hospitalized with complaints of repeated vomiting and weight loss (18 kg in 8 months); and incessant belching and nausea/regurgitation for 30 days subsequent to her COVID-19 treatment. After all the normal medical radiological reports, appropriate psychological and psychiatric evaluations were done. Incessant belching warranted a simple and flexible cognitive psychotherapy for histrionic personality with a therapeutic assessment technique. A total of 6 h of psychotherapy was delivered in three sessions. The belching and vomiting came down by 75% after the first extensive session, and almost 100% after the second session. However, mild belching reappeared, and after the termination-cum-booster session belching subsided till discharge and the first follow-up after 2 weeks.

Key words: Avoidant restrictive food intake disorder, Belching, Histrionic personality, Therapeutic assessment

Freud's definition of "hysterical neuroses" can be credited with giving rise to the modern histrionic personality [1]. A pattern of exaggerated yet fleeting displays of emotion, attention-seeking behaviors, suggestibility, and dramatic flair are all signs of histrionic personality disorder (HPD) [2]. Traits linked to HPD are significantly less studied; however, they are reported to affect 1–3% of the general population [3] and to affect women twice as often as males [4]. HPD is one of the Cluster-B personality disorders that lack empirical study and is seen as having "flat" literature growth [5]. Little is known about HPD and how it develops; nevertheless, as HPD patients tend to crave attention from their caregivers, psychotherapy should concentrate on addressing this issue [6]. Histrionic personality traits are associated with increased irritability during conscious sedation endoscopy [7] but the literature on its linkage to supragastric belches is silent. Supragastric belching is voluntary or behavioral [8] and repetitive [9]. Belching can be loud and socially disruptive, leading to embarrassment and increasing social isolation [10]. The literature on clinical case reports and series recommends psychological and behavioral treatments for belching. Interestingly, the history of psychological treatment for belching dates back to the 1970's, when hypnosis [11] and the use of self-administered response-contingent shock to reduce the frequency of belching were found beneficial.

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CASE REPORT

A 26-year-old unmarried female bank employee with Cluster B personality traits with no past or family history of psychiatric illness presented with complaints of recurrent vomiting, rumination of food, regurgitation of food after eating a small amount, avoidance of specific food items, marked decrease in the intake of food, significant weight loss (18 kg in 8 months), sensation of abdominal fullness after eating a small amount of food, sensation of something stuck in throat persisting all day, query dysphagia, headache, burning sensation in the chest, fatigue, pain in legs, constipation with exacerbation for 15 days with an increasing sensation of food about to regurgitate persisting all day, increased frequency of rumination of food, and belching throughout the day leading to significant socio-occupational dysfunction. She was facing these symptoms for the past 8 months after COVID-19 exposure. Subsequent to COVID-19 treatment, the patient developed vomiting symptoms which never subsided completely. Treatments were sought in gastro, ENT, and medicine departments. All medical radiological reports were normal. With 1-month psychiatric treatment for avoidant

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restrictive food intake disorder (ARFID), food intake improved slightly. However, belching and vomiting with the slightest body movement continued for 8 months but more incessant in 1 month before hospitalization. A series of clinical interviews and Lorazepam-assisted interviews revealed no significant stressors; hence, the referral for psychotherapy came with a suggestion to explore narcissistic personality. Subsequently, after a detailed discussion among the treating team on current symptoms and its course, a brief, but intensive HPD-focused cognitive therapy was designed without defining the duration of therapy.

Millon clinical multiaxial inventory (MCMI-III) [12], Maladaptive Covert Narcissism Scale [13], and Adaptive Overt Narcissism Scale [14] were administered before therapy. The mental status examination was normal. MCMI-III revealed that the patient had a syndromal histrionic, not narcissistic personality and this was corroborated by negative findings from the other two tools. Hence, a brief and intensive cognitive therapy focused on histrionic personality rather than ARFID/rumination regurgitation disorder was planned. Urgent somatic symptoms warranted a simple and flexible cognitive case formulation. The patient was well-groomed and well-behaved in the inpatient ward.

The chief complaints also indicated more toward HPD and not a narcissistic personality disorder. Eye-to-eye contact was sustained, rapport was established, and psychomotor activity was within normal limits. The speech was spontaneous, coherent, relevant, and goal-directed; with rate, volume, tone, reaction time, and productivity being normal. Affect was euthymic in full range and with the presence of reactivity appropriate to thought content.

Therapy Planning and Progress

Initially, three therapy sessions following the therapeutic assessment (TA) intervention model were planned. This model was used to keep the education, occupation, and comprehension level of the patient in view and also in anticipation of the active and immediate shift of attention from belching to self-exploration. Therapy was conducted in the inpatient ward. Initially, the number of sessions was open-ended and planned to complete theme-specific worksheets, though time was noted. The total duration was of 6 h (3+2+1) delivered in 3 sessions+1 termination-cum-booster session for 45 min before discharge. The participation ratio between the therapist and the patient was 40:60. Sessions were semi-structured and need-based. Self-description and self-awareness were assessed at three levels (self, as a family member, as an employee), stage-specific life events (childhood, adolescence, and adulthood) charting and intentional coping, and various worksheets related to emotions and unintentional coping (what changes my mood, emotional IQ and identifying emotions, identifying my stress symptoms and signs, histrionic personality emotional spectrum, feeling connected and understood), and family psychoeducation. Intentional coping focused on potential stressors such as conflict with the boss, acute myeloid leukemia in the nephew, childhood stressful incident, one stalking incident, guilt about the sexual involvement with the boyfriend about whom the family was not aware, and a new workplace were also discussed. The patient accepted the fact that her predominant coping has been avoidant and showed interest to know alternative problem-solving coping in those specific situations.

Key Illness-Related Factors

The patient received excessive family attention (predisposing factor). The precipitating factor was COVID-19 and a brief episode of conflict with the boss after that. The patient and family members unknowingly acting on the avoidance coping (e.g., transfer) perpetuated illness. Many protective factors were there (stable job, socioeconomic status, no adversity, family support, normally expressed emotions by family members, and stable relationship).

Therapy Outcome

Belching and rumination regurgitation came down by 75% after the first extensive 3 h session with the occurrence of belches sometime in the next 48 h; and reduced almost 100% after 2 h of the second session with other improvements such as eating adequately, less subjective distress, regurgitation, nausea, and vomiting. However, mild belching reappeared after a few days subsequent to the stressor, which subsided completely after the final 1-h session. One booster session was held before the formal termination of therapy. The patient was belch-free till discharge and the first follow-up after 14 days.

DISCUSSION

A therapeutic and collaborative assessment is an assessment-focused intervention model [15] where the patient participates actively in the scoring and interpretation of tools, therapy-related worksheets, and processing of emotions while working on the worksheets. This collaborative engagement perhaps potentially produced the change in the patient [15], which in turn, reduced her covert irritability and finally belching reduced automatically. This helped the patient to shift the story; she held about herself to build a more coherent, correct, pragmatic, and compassionate story about herself [16]. Since we included the perspective of family systems [17], self-verification theories [18], and family psychoeducation, the sessions perhaps facilitated the progress in therapy quickly.

Intensive processing of emotions and coping strategy used in different stressful situations perhaps helped the patient to see the gaps between her perception, self-awareness, and actual behavior or may have corrected her underlying information bias which is common in HPD [19]. The process perhaps moderated the unconscious patterns of reinforcement; the patient had received from significant others or challenged the core belief of being inadequate [20].

Earlier studies reported the benefits of supportive therapy and patient psychoeducation resulting in a significant reduction of belching in aerophagia [8], conversion disorder with mild depression, cognitive therapy for belching in bulimia nervousa [9],

and hysterical serial belching [21], Although except for a few, the earlier case reports do not specify the structure, contents, and duration of psychotherapy conducted for various patients with belching. Compared to these studies, our approach was the quickest to provide significant relief to the patient. In contrast to eight sessions of supportive therapy and psychoeducation [8] and six sessions of cognitive therapy [9], TA reduced the number of sessions to three with a 100% success for our case. Instead of the weekly sessions, we had consecutive sessions in 4 days. We focused on finishing definite contents of TA in extended duration (e.g., 3 h, 2 h), therefore did not follow the recommended psychotherapy session duration of 45–60 min. In all cases reported on belching, the psychological intervention was focused on belching, while in our case, no therapy content targeted belching reduction rather all contents focused on HPD. The previous reports also highlighted the behavioral tasks that the patient was supposed to do at home after therapy sessions, whereas, in our case, there was no homework for the patient. Rather, homework was given to the close family members to express their perceptions, thoughts, and beliefs about the patient so that patient's thought regarding how other people think about her can be matched. This was also a unique technique used in this case.

TA was proved to have potential as a brief and intense intervention and can be tested in similar cases. Flexibility to customize the therapy worksheets and routine assessments used in the therapy keeps the therapy motivating for the patient.

CONCLUSION

The patient's active engagement through histrionic-personality-focused TA was the key to bring out the target outcome even without any deliberate effort to reduce belching symptoms.

AUTHORS' CONTRIBUTION

SS – Conceptualisation, methodology, therapy delivery, and manuscript preparation; MK – Detail case history and ward course management; PY – Supervision of treatment and management; SB – Initial case management; NKD – SR in-charge of the case; GH – Consultant in-charge and overall case management; and PS – Overall supervision and manuscript editing.

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