Published in final edited form as:

Psychiatry Res Case Rep. 2023 December ; 2(2): . doi:10.1016/j.psycr.2023.100139.

Pharmacotherapy for comorbid antisocial personality and obsessive-compulsive disorder: A case report

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Keywords

Anti-social personality disorder; Obsessive-compulsive disorder; Anxiety; SSRI; Comorbidity

Introduction

Obsessive-compulsive disorder (OCD) is characterized by distress and impairment resulting from unwanted/intrusive thoughts, images, or impulses (obsessions) and ritualistic behaviors (compulsions) performed to ameliorate the attendant anxiety and distress (American Psychiatric Association, 2013). Personality disorders are frequently diagnosed in individuals with OCD (Thamby and Khanna, 2019), though comorbidity between antisocial personality disorder (ASPD) and OCD appears to be exceptionally rare (Pena-Garijo et al., 2013). One reason for this rarity may be due to decreased treatment-seeking in this population. Another may be that the thoughts and behaviors experienced in OCD are often experienced as unwanted or even foreign (i.e., ego-dystonic), by contrast to the more ego-syntonic and pervasive symptoms of ASPD, such as disregard for the rights of others and engaging in risky/immoral behavior. These ASPD symptoms may struggle to coexist with some OCD domains such as a fear of causing harm to others, acting immorally, or acting deceitful (Cervin et al., 2021), decreasing the overall prevalence.

Although selective serotonin reuptake inhibitors (SSRIs) are often used as a first-line therapy for patients who have OCD, their efficacy in the presence of comorbid ASPD is unknown. Moreover, many personality factors can impede interventions for ASPD, including anger, social conflict, conflicting value systems, and maladaptive coping mechanisms (Thylstrup et al., 2017). The social manipulation and lying often present in ASPD can impact the patient-provider relationship (Bateman et al., 2013). Individuals with ASPD are at increased risk for medication misuse, overdose, and illegal drug use (Black et al., 1995). A focus on obtaining short-term external rewards could decrease compliance and willingness to remain

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Declaration of Competing Interest
Anastasia Jankovsky declares no conflicts of interest.

on a long-acting medication regimen in the absence of immediate benefit (Daughters et al., 2008).

While interventions for OCD have been highly successful, the prognosis for ASPD is poor and interventions have been less successful (Fisher and Hany, 2023); nevertheless, some individual symptoms can be treated successfully. For example, aggression, a common symptom associated with ASPD (Velotti et al., 2016), can improve with treatments such as atypical neuroleptics, SSRIs, and mood stabilizers (Fisher and Hany, 2023; Velotti et al., 2016). Treating symptoms of ASPD through SSRIs provides hope for individuals who present with this challenging symptom profile. Moreover, this intervention dovetails with first-line SSRI recommendations for treating OCD (Koran et al., 2007), which may be particularly relevant in these comorbid cases.

The present case study thus examined the effects of an 18-week clinical trial with fluoxetine on OCD and anxiety in a patient with comorbid OCD and ASPD. Results indicated that fluoxetine was modestly effective by the study's end, but that symptoms returned to baseline after a one-year follow-up. We discuss the difficulty of managing the interacting comorbid diagnoses.

Psychological history

The presented patient was a 26-year-old male with previous diagnoses of OCD (diagnosed at age 22), generalized anxiety disorder (age 12), and attention-deficit/hyperactivity disorder (ADHD; age 13). His-chief complaints included an inability to buy new objects, having to place objects in correct spots, arranging objects in his kitchen with labels facing out, draping towels in his bathroom in ways that feel right, and a fear of losing control and hurting others.

During the clinical interview, the patient reported an "uncontrollable temper" as a child. This provoked numerous physical fights that resulted in multiple concussions and suspensions from school. After turning 15 years old, he shared that he partook in illegal activities (auto theft, stealing, and breaking his parole), frequently lied to others, was impulsive, and continued to engage in physical fights. At age 16, his mother removed him from high school because she feared he would have legal trouble. Despite her efforts, at 18-years old he was incarcerated for 7 months for gun possession and burglary. After serving his sentence, he immediately violated parole and went back to prison a second time. When the assessor asked what the barrier was to comply with parole, he replied that it was too much work to adhere to the guidelines and preferred prison. When released again, he returned to prison a third time after violating parole once more after stealing a vehicle and illegally possessing a firearm.

Of note, during his first incarceration at age 18, the patient noticed the onset of unwanted and persistent thoughts that his sentence was elongated and that the corrections officers forgot to let him go. The subsequent anxiety and distress this caused led to behaviors such as excessive counting – for example, of the letters in words. During his second prison sentence, these behaviors worsened, with repetitive behaviors done in sets of three (e.g., cleaning his cell; mopping the floor). After his third sentence, he endorsed a worsening and

broadening of his unwanted thoughts and behaviors. For instance, he reported that due to an indescribable feeling that something terrible would happen, he could no longer buy new items unless he already had a specific place in his home for them. This prevented him from making any unplanned purchases of clothes or food.

While previously engaging in physical fights at school, the patient now endorsed ego-dystonic, anxiety-inducing thoughts surrounding the fear of harming others and worrying that he might lose control and violently harm someone (e.g., rape, stabbing, or shooting), adamantly denying any intent to do so. Other than past school fights with peers, he denied any violent behavior. His-concern about potentially engaging in violence has since morphed into a fear of accidentally committing a crime and being incarcerated again. Given his offense history and his personal knowledge/experience with being incarcerated, he found these intrusive thoughts to be exceptionally distressing. When experiencing these intrusive thoughts, he would find himself compulsively balling up his right hand and stroking his face three times in a row. If he were unable to complete this action, the intrusive thoughts would persist and be difficult to control.

Medical history and past pharmacological treatment

The patient was 6′2″ and ~240lbs. He reported a history of alcohol and drug abuse, describing himself as “getting hooked fast” on multiple substances including Xanax, fentanyl, and benzodiazepines. The patient was prescribed Suboxone in 2013 and Methadone in 2020 to combat his opioid addiction. At the time of his presentation and treatment with us, the patient was not using any substances except for nicotine. He previously took Zoloft (unknown dose) in 2008 for depressive symptoms but quickly discontinued it, as he believed it did not help. He was also taking Adderall (unknown dose) from 2015 to 2019 for ADHD. Despite having experienced multiple head injuries and visits to the emergency department throughout his childhood, the patient denied loss of consciousness for more than ~20 s and was never admitted to the emergency department.

Treatment and outcomes

Physical exam, urine tests and electrocardiogram prior to treatment were unremarkable. Phlebotomy was difficult due to his history of intravenous drug use; it was determined that in the absence of any concern for medical illness standard blood tests, which are not routinely done prior to starting antidepressant treatment, were not required.

Following baseline assessment, the patient began an 18-week research trial of fluoxetine, as part of a research protocol consisting of fluoxetine treatment with periodic clinical assessments and MRI scans (NCT04131829). This protocol was approved and overseen by the Yale Institutional Review Board. For successfully completing initial assessments (baseline ratings, fMRI scans, and two electroencephalography sessions), the patient received compensation of $275. Clinical assessments, including the clinician-rated Yale Brown Obsessive Compulsive Scale (YBOCS; Goodman et al., 1989) with a licensed psychologist, were completed every 3 weeks from baseline and were incentivized by additional monetary payments. Weekly phone calls monitored clinical changes, difficulties

with the medication regimen, adverse events, and medication compliance. Treatment was overseen by a licensed and board-certified psychiatrist. The patient never reported a missing dose. Fluoxetine dosing started at 10 mg and increased by 10 mg each week to a target dose of 40 mg by week 4, which was maintained for the duration of the 18-week trial.

Baseline YBOCS was 31, corresponding to severe symptoms. YBOCS was stable through the first 6 weeks of treatment (Fig. 1). On week 6, two weeks after reaching the full 40-mg dose of fluoxetine, the patient stated he began feeling less anxious (see also Fig. 2), though this was not reflected in a change in YBOCS score (31). He reported no side effects. YBOCS gradually declined following week 6, reaching a score of 25 by 18 weeks. This is a modest change (~20% improvement) and enough to produce some meaningful benefit. Indeed, by week 15 he began acknowledging qualitative changes in behavior; for example, he no longer needed to wash objects immediately and place them in the same exact spot, and he found himself forgetting to follow through with some of his routine compulsions.

Anxiety was assessed using the Beck Anxiety Inventory (BAI; Beck et al., 1988). Baseline BAI was a 20, corresponding to moderate anxiety, and changed little over the first six weeks (Fig. 2). At week 9, when the patient had been on 40-mg fluoxetine for five weeks, his BAI score decreased by 8 points. By the end of the study (week 18), the patient's BAI reached a score of 1. As seen at the one-year follow up, his score was still lower than baseline, but had increased to a total of 7.

After the patient completed the structured 18-week trial, after consultation with the study psychiatrist (CP), and because he experienced partial response with no side effects, fluoxetine dosage was increased to 60 mg/dy. Medication management was then overseen by his primary care provider and formal assessments (YBOCS, BAI) were not conducted. After recontacting the patient for the one-year follow-up, he explained that over time he became increasingly anxious when he noticed that he had been forgetting to perform his compulsive behaviors. This distress led him to discontinue fluoxetine several months since completing the study, without consulting with any of his providers. At the one-year follow-up symptoms had worsened, perhaps due to this decision to discontinue a treatment that appeared to be producing some benefit (Figs. 1, 2).

Discussion

This case report highlights the potential challenges when treating a patient with comorbid OCD and ASPD, as well as the potential effectiveness of SSRI treatment—here, fluoxetine—for such cases. SSRI monotherapy is a well-established first-line treatment for OCD (Koran et al., 2007), but to our knowledge, there are no studies demonstrating the efficacy of fluoxetine for individuals with comorbid ASPD and OCD. Although fluoxetine was helpful to this patient, as seen both in clinical ratings and his subjective report, the patient still discontinued its use. There appear to be three reasons for this. First, in the absence of the study's structure and positive reinforcement (payment) for ongoing participation, he no longer had external incentives; such lack of structure can be difficult for someone with ASPD to accept (Jemal et al., 2022). Second, as symptoms improved further on the 60-mg/day dose (according to his report; YBOCS was not collected after week 18), he

became uncomfortable with his perceived ‘lack of control’ and felt distressed whenever he realized he had not performed a compulsion. This need for control and his distress when feeling out of control are consistent with his diagnosis of OCD. It is also widely accepted that patients with ASPD lack insight into their behaviors and are typically unmotivated to change (Daum, 1994) which, coupled with his need for control, could have contributed to his decision to discontinue treatment. Lastly, ASPD-associated impulsivity may have contributed to the decision to discontinue fluoxetine. Instead of scheduling a call with a physician to discuss treatment options, he halted use of psychiatric medication without any consultation, or consideration of negative consequences.

While no additional treatment was provided for ASPD due to the restriction of the randomized clinical trial’s treatment protocol, the need for addressing the ASPD may be crucial. This is challenging, given that a qualitatively and/or quantitatively significant treatment fails to exist both for psychosocial interventions (i.e., CBT and DBT) and medical treatments for ASPD (Fisher and Hany, 2023). Nevertheless, for patients with ASPD who are seeking treatment to manage their OCD symptoms, we suggest that viewing their ASPD as discrete symptoms may be crucial for outcomes. For example, impulsivity may be addressed through contingency management to reinforce medication consistency as well as aiding in discontinuation of problematic substance use (Gibbon et al., 2010).

Seeking both a therapist and psychiatrist for treatment may lead to difficulty in report building, as this is already a difficult task for someone with ASPD (Glenn et al., 2013). In the current case, our clinical trial allowed the patient to have a singular clinician for progress monitoring, which was beneficial for report building and trust in treatment. If the provider is doubtful about the validity of self-report forms, a multi-method, multi-rater approach can be used (i.e., measuring frequency of problematic behavior, reluctance to continue medication, changes in thoughts/emotions, difficulty regulating anger; soliciting ratings from family) to improve reliability and validity. By closely monitoring and treating ASPD symptoms that interfere with OCD treatment, providers can more efficiently address the OCD.

Limitations

This study is limited by the typical problems associated with case studies; it is impossible to identify causal connections with confidence in individual patients. Another limitation is that only OCD and anxiety symptomology were systematically measured; we may have overlooked other relevant variables (e.g., ASPD severity). However, qualitative (clinical evaluations, weekly check-ins, semi-structured interviews) and quantitative assessments (self-reports) provide a clear picture of change in symptomology.

Conclusion

Understanding how comorbidity impacts pharmacotherapy outcomes is a crucial step for developing treatment plans for participants with uncommon symptom presentations. Although studies on ASPD efficacy are scarce (Matusiewicz et al., 2010), a patient presenting with ASPD and OCD may still experience symptom reduction and reduced clinical significance of OCD symptomology if the intervention is well structured. However,

providers may face barriers such as treatment non-compliance, particularly in settings without reasonable external incentive structures.

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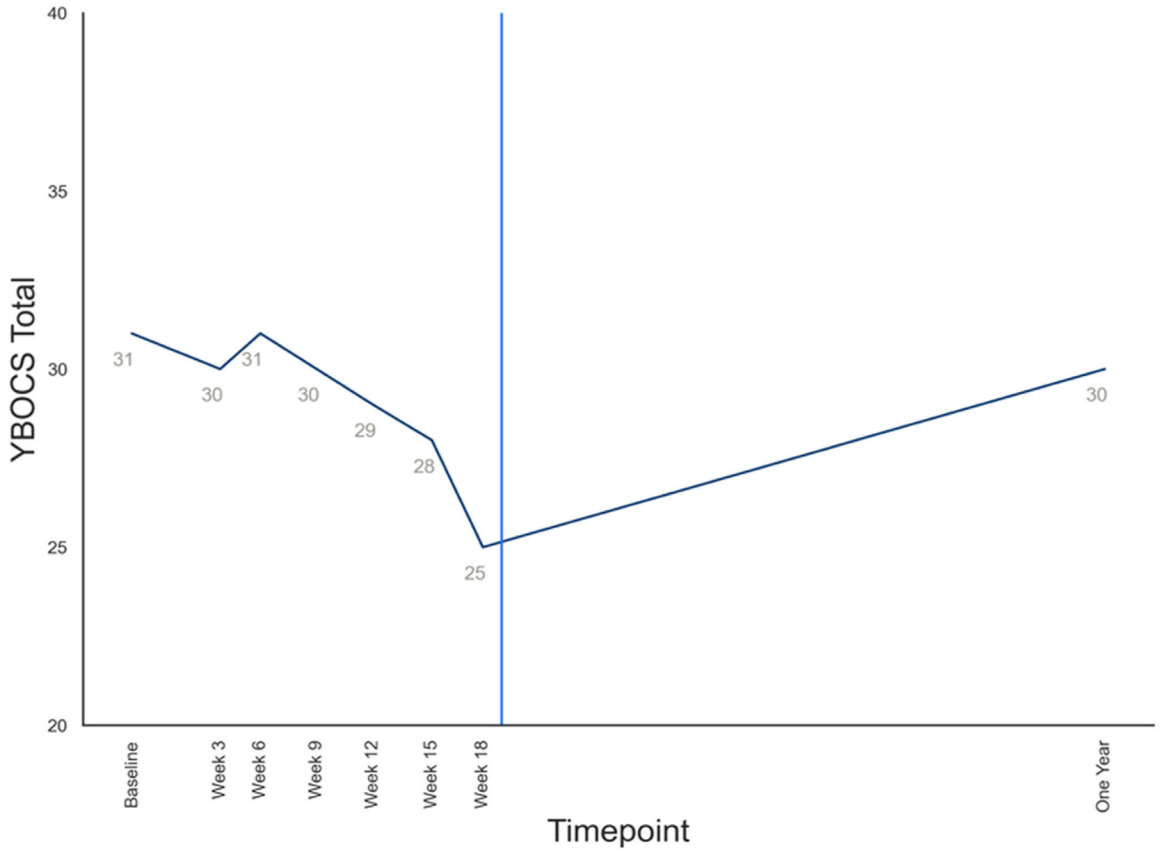

Fig. 1.

Patient's baseline Yale-Obsessive Compulsive Scale scores through 18 weeks of fluoxetine treatment and at one year follow-up, at which point he had discontinued the medication.

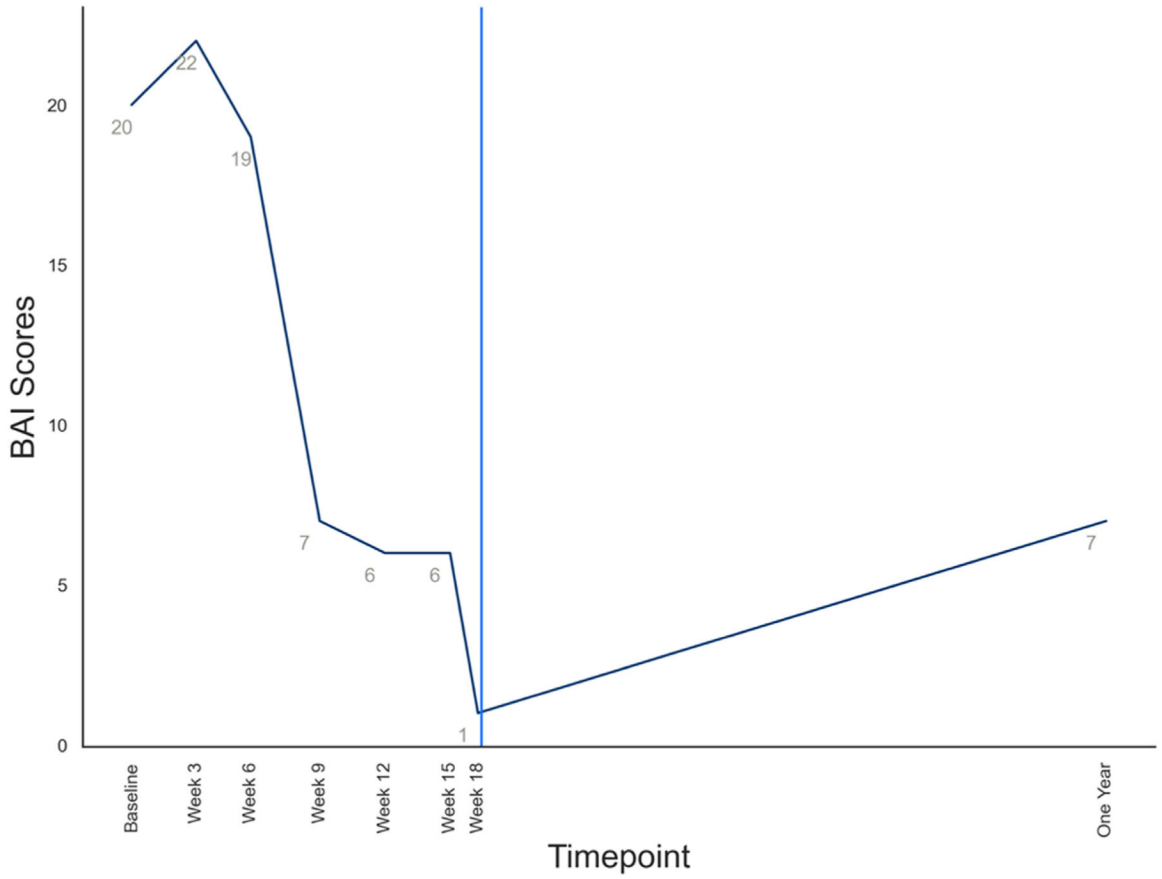

Fig. 2.

BAI scores from baseline to one-year follow-up. From a baseline of 20, the patient's score decreased to a 1 by the final week of the fluoxetine trial.