

Anubhoothi: a psychopathology of unusual sexual experience

Abstract

The case history and management of a 26 years old adult is reported who presented with an unusual symptom of sexual experience, in the background of symptoms of depression and anxiety; had been given multiple diagnoses at multiple points of time and treated with multiple medications. On establishment of rapport, he revealed details of his unusual experiences, which had been unexplored. When he was about 11 years and ten months, he sat next to a lady; he could perceive a particular experience for the first time in his life. And next time with another lady too he perceived a particular type of smell ("madaka gandha" meaning an intoxicating smell) along with the other feelings. He began to have these feelings whenever he was in the vicinity of a female except his mother and sister. The smell reminded him of roses vaguely and was at least ten to 20 times more pleasurable than an orgasm that he got with masturbation. These feelings were more pleasurable than he could ever imagine and happened always with the presence of a female in the vicinity. This was never associated with periods of unresponsiveness or any other history suggestive of seizures. He titled the experience as "anubhoothi". These experiences occurred on a regular basis for a period of ten months following which there was abrupt cessation of the same, without any intervention. Later he developed all symptoms. A coordinated management plan spearheaded by the multi-disciplinary treatment team could bring down his symptoms as well as make him functional. This case indicates that it is essential to explore abnormalities of experiences to understand the psychopathology and plan management.

Keywords: Depression. Anxiety. Diagnosis. Orgasm. Masturbation.

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Introduction

Mental illnesses can present with various signs and symptoms; sometimes, these signs and symptoms may not fit specific diagnostic criteria. When the presentation is atypical or not keeping with established diagnostic criteria, there can be delay in diagnosis and treatment. In clinical assessments, focus is invariably on disorders of thought, mood, behaviour, cognitive functions, or perceptions. Disorders of unusual experiences have not received due attention in the clinical assessments. The authors recently had a person distressed by an unusual abnormal experience, a rather rare presentation. Here the authors report the case of a person who presented with chronic psychological distress in the background of such unusual experiences, but was given multiple diagnoses at various points of time and received multiple treatments before he came to the National Institute of Mental Health and Neuro Sciences (NIMHANS), Bengaluru.

Case report

Mr. A, 26 years old male who completed Pre-University Course (PUC), presented with complaints of feeling tired all the time. He did not want to meet people at all and not being able to enjoy any activity since the last ten years. He was avoiding social functions because he had found it was difficult to initiate or maintain conversations with people. Parents noticed his problems when he decided to drop out from the school for a year after his tenth standard.

Although, he rejoined school a year later and he found it was difficult to cope at school and barely managed to complete his studies. After dropping out from the school, he was always at home and caused his parents a great degree of concern and was taken to multiple psychiatrists by his parents. He has had multiple diagnoses at various points of time—obsessive-compulsive disorder, schizoaffective disorder,

and social anxiety disorder, and had been given varying doses of antipsychotics (risperidone, aripiprazole, amisulpiride, and paliperidone), antidepressants (fluoxetine, sertraline, dothiepin, and escitalopram), and mood stabilisers in various combinations. There had been no apparent improvement with any of these treatments. Following consultation in the outpatient department, he was advised admission for detailed evaluation and diagnostic clarification. Initial mental status examination (MSE) revealed only depressive cognitions; however, on building up a better rapport with the treatment team, patient expressed a wish to reveal something that had been troubling him for a long time.

When Mr. A was about 11 years and ten months, and sat next to a lady (he did not explain the situation) he could perceive a particular experience (he had goose bumps, a kind of soothing heat, a feeling that he had reached another level of existence and arousal, a feeling of time passing slowly) for the first time in his life. And next time with another lady too he perceived a particular type of smell (“madaka gandha” meaning an intoxicating smell) along with the other feelings. This smell attracted him to other females. He began to have these feelings whenever he was in the vicinity of a female except his mother and sister. The smell reminded him of roses vaguely and was at least ten to 20 times more pleasurable than an orgasm that he got with masturbation. These feelings were more pleasurable than he could ever imagine. He reported that he had multiple instances of perceiving the smell every day, always temporally correlated with the presence of a female in the vicinity. This was never associated with periods of unresponsiveness or any other history suggestive of seizures. This occurred at a stage of life when he was not able to make sense of it rather than just to enjoy it. Mr. A reported that he had been unable to confide in anybody regarding this experience apart from a few of his friends who were baffled by it. He titled the experience as “anubhoothi”. These experiences occurred on a regular basis for a period of ten months following which there was abrupt cessation of the same, without any intervention or treatment.

Following the absence of these experiences, he became sad at not having the same level of enjoyment as before. He began searching for the lost experience—mainly asking friends, consulting books on sexual literature, but was at a loss as he could not obtain it from anywhere. At school, he found his friends talking about girls and the pleasure from masturbation; but unlike them, he could never enjoy these because he had experienced a sensation much higher in pleasure, one that never came back despite anything that he did. When his friends were discussing about girls or masturbation, he was not interested and his peers began to make fun of him on this regard. He began to believe that all this had happened because of not having had sex at the age of twelve and he strongly believed it. He began to feel low and thought that he was ‘incapable’ or ‘inferior’ compared to his peers. This was when he started avoiding meeting anybody, not being interested in studies and started feeling afraid to talk to elders or children of the same age. Later, he started to think that all boys of his age masturbate and he was not doing it and this may be the reason for all his problems. So later on, he started masturbating and he felt that he was addicted to masturbation and started feeling guilty. He felt that he

had lost his “personality, self-confidence and ability to keep confidentiality”. He reported sadness of mood and started thinking that somebody must have done some black magic and later avoided interaction with neighbours and relatives. Also he began to believe strongly that his paternal relatives were trying to poison him which his family did not agree with. This belief of them trying to poison him remained an overvalued idea. He spent a large proportion of his time at religious institutions as he found solace in praying to God in begging for his “anubhoothi” to come back. Mr. A comes from a family with religious beliefs that are more synonymous with a Christian minority and hence stress upon these beliefs a great deal. Patient also believed the same for few years and later he began to practice a different system of belief which family did not like, but he was firm in his decision and continued it. He thought that having sexual relationship with a female may give him the “anubhoothi” back. He attempted to have sex with a sex worker which failed as he was threatened by unknown people. His belief that having sexual intercourse with a lady will cure all his problems persisted. Patient was brought to different doctors in different systems of medicine and counselling and hypnotherapy etc. But there was no relief in the symptoms. He started thinking that the future is bleak and found no purpose in living. He started thinking of himself as a burden to the family. When he was 24 years old, he consumed 30 tablets of alprazolam wanting to end his life and was saved following hospitalisation.

During the admission, it was observed that apart from depressive cognitions, MSE revealed multiple misconceptions regarding sexuality. He also reported harbouring an overvalued idea of his relatives having tried to poison him by mixing it with his food. Schizotypal Personality Questionnaire (SPQ)[1] was applied and it showed confirmation on multiple items. He was started on trifluoperazine 1 mg after withdrawing all other medications. Psychological assessment revealed the intelligent quotient (IQ) of 103 on Binet Kamat test[2] dictating average intelligence. The 16PF test[3] revealed presence of low frustration tolerance, introvert, cold, and aloof. The Rorschach inkblot test[4] revealed presence of low ego strength. Object sorting test[5] showed no thought deviance. Neuropsychological assessment using NIMHANS Neuropsychology Battery[6] revealed presence of left frontal involvement.

Psychosocial intervention was carried out by a psychiatric social worker over a series of sessions while the patient was admitted. Psychoeducation regarding the illness helped him to understand his problems and the supportive environment allowed him to ventilate his distress. His knowledge on sex and sexuality was limited and filled with misconceptions for many years. Since he was never involved with girls like his friends were doing, he believed that he was inferior to them in sexual matters. In course of time, he developed cognitions that he was inferior to everybody because he could not derive the same amount of pleasure from masturbation as everybody else did. He had attained the greatest degree of pleasure from his adolescent “anubhoothi” experiences and masturbation could never equal it. These cognitions gradually developed into a state wherein he felt inferior and could not interact with others. He had significant guilt feeling over his masturbatory practices, though the frequency of masturbation was

occasional. This guilt regarding masturbation was associated with his religious beliefs also. He had a great deal of confusion regarding whether masturbation was right or wrong in his religion. He started believing that he could not derive as much pleasure as others because he was doing wrong and would never be pardoned for his sins. Sex education was carried out in detail and the social worker was able to normalise his concerns regarding lack of interest in females, flirting, fantasising about sexual activities, and discussing all these with friends. After five sessions, he achieved adequate knowledge and his confidence level improved and social anxiety decreased markedly.

In addition to this, patient also had a strong belief that the “anubhoothi” will come back and he had been waiting for the same for the last 14 years. When the psychiatric social worker attempted to examine the lack of logic in the “anubhoothi” experience, patient was distressed and reported being unable to forgo its importance. He was not ready to give up the “anubhoothi” and still wanted to wait for the same to become a ‘complete normal’ man and recover from all his problems. He believed that sexual intercourse with a female or getting married and marital sex will help to regain the “anubhoothi”. Since his core belief did not change, an attempt was made to discuss the pros and cons of waiting for the “anubhoothi”. Along with his effort, a discussion was done on what he had lost in these years and what all he could have achieved so far and the importance of thinking about his future. Patient agreed with the same and started being ready to let go of the “anubhoothi”. Preoccupation with “anubhoothi” decreased markedly over the sessions.

Poor knowledge about the illness was noted in the family members along with significant expressed emotions in father (father was over-involved and critical towards the patient). Psychoeducation regarding the illness was given to all family members. Through the psychoeducation process, family members could acquire adequate knowledge about the illness and the expressed emotions decreased markedly from father’s side. Later, the family was highly supportive and ready to help the patient in all aspects. A discussion was held regarding the patient’s future plan with family members. Marriage was not a concern for family. Patient was interested to start an aluminum fabrication business with his friend. Family agreed for the same.

When patient was discharged, he did not have any depressive cognition; social anxiety symptoms had decreased markedly and he had acquired adequate knowledge in sexual matters. His preoccupation with “anubhoothi” had come down. He left with a plan to start aluminum fabrication business with his friend. Activities of daily living were discussed till he involved himself in the business. Patient and family reported that he was improved up to 75% when he got discharged.

In follow-ups, he maintained improvement up to 70%. He had started an aluminum fabrication business with his friend. Later he was not able to continue follow-up in NIMHANS as it was very far from his hometown. But telephonic follow-ups were carried out with the patient and father. After discharge, within nine months patient got married and had maintained improvement. Currently, he is working as a

driver. He maintained 90% of global improvement for the last two years. But he still wanted the “anubhoothi” to come back. Reportedly there are no complaints regarding his sexuality or his sexual life at present.

Discussion

Here Mr. A had presented to multiple psychiatrists and had been given multiple diagnoses in his lifetime; there had never been an instance wherein he felt comfortable enough in opening up and talking about his “anubhoothi” experiences which had caused him trouble. Here we would also like to highlight the nature of presentation of psychiatric symptoms. Though he had presented with multiple symptoms, he improved well with an optimal combination of pharmacotherapy and psychosocial interventions. In this patient, typical cognitive behavioural work did not work. In some patients, it is very difficult to address the core belief like in depression or other anxiety disorders. Here authors focused primarily on patient’s functionality. Distracting patient from the core belief and other symptoms, discussion of future plan, working with family etc. helped in this case.

This case demonstrates an unusual abnormal but intense pleasurable experience “anubhoothi” which had significant impact on the patients’ mood, behaviour, and life. The impact resulted in distress which interfered with person’s life and adjustment, and caused depression and anxiety, needing treatment. The treating team could not find the above mentioned symptoms or signs even in the basic psychiatry textbooks—Fish’s clinical psychopathology: signs and symptoms in psychiatry[7] and Symptoms in the mind: an introduction to descriptive psychopathology.[8]

The initial lack of response to psychotropics was perhaps due to lack of appropriate exploration and management of the “anubhoothi”. After addressing these issues, psychoeducation, and clarification of sexual concerns, the patient’s distress was reduced and he progressed with his life and career.

It is difficult to speculate on the pathophysiology of this “anubhoothi”—a pleasurable intense sensation related to smell. This was not suggestive of olfactory hallucination or illusion, rather a cue-related recall of memories of the experience. The neuropsychological evaluation suggested a left frontal lobe involvement. This case indicates the need for exploring abnormalities of experiences as these would not be spontaneously reported and may be a factor for inadequate response to management.

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