Obsessive Slowness: A Case Report

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ABSTRACT

Obsessive slowness is described to be a syndrome of extreme slowness in ways various tasks are performed. Its existence as an independent syndrome is challenged by authors, who regard it to be a part of obsessive compulsive disorder. Behavioural techniques of prompting, pacing and shaping are recommended for treatment of this condition. We describe here a case of a 21 year old male patient who presented with debilitating slowness. Patient responded to a combination of behaviour therapy (thought habituation and exposure) and pharmacotherapy (fluoxetine and thyroxine). Diagnostic difficulties and management issues are highlighted.

Key Words: Obsessive slowness, Diagnosis, Behaviour

Rachman(1974) introduced a case syndrome, termed "primary obsessive slowness". It is characterized by prominent debilitating slowness especially in self-care behaviour, extreme meticulousness, absence of an increase in anxiety or discomfort either before or following the behaviour (or with initiation of treatment) and relative lack of resistance. Subsequently, others published case reports or case series (4-10 patients) that detailed features of this syndrome (Hilsbury and Morely, 1979; Bennun, 1980; Clark et al., 1982; Hymas et al., 1991; Ratnasuriya et al., 1991; Takeuchi et al., 1997). Veale (1993) challenged the proposed syndrome by pointing out that slowness in most of these patients is secondary to behavioural or mental rituals, aimed at suppressing or neutralising obsessional thoughts. It may be due to a very (minutely) detailed plan for future rituals.

We described here a case of a 21 year old male who presented with extreme slowness.

CASE

Mr. P.K., 21 years old unemployed man from middle socio-economic Hindu nuclear family of urban background presented with a 6 years history of doing things very slowly. At the time of presentation, the patient was taking 6-7 hours to bathe and 13-14 hours in self-care activities. He would divide each act of self-care (e.g. bathing) into number of small steps. For each of these steps, he would spend variable periods of time deciding on whether to do it or not, after considering the pros and cons of each behaviour.

At 20 years of age, he started walking in a peculiar manner. He would repeatedly take steps forward and backward and stop and start in an attempt to prevent his face from getting distorted. He regarded this thought as senseless and tried to resist it, but he could not do so. He also developed obsessional doubts regarding distortion of face and having left something behind. After 8 weeks of treatment (approximately 100 sessions each of thought habituation and exposure), time spent in bathing, moving out of bed, and in moving from one place to another reduced by half. He stopped passing stool in his clothes and started bathing on his own on alternate days. But he continued to walk in a peculiar manner and no change in repetitive checking rituals was noted. During the course of therapy, he frequently showed resistance by refusing to co-operate for sessions.

After 3 month of ward stay, therapy had to be discontinued as patient's father had pressing official engagements. Outpatient treatment was not possible as the patient was from another township. At 9 months follow up, he continued to maintain improvement.

DISCUSSION

The present case highlights the difficulties inherent in the concept, diagnosis and management of a patient with slowness. Though the term obsessional slowness is established, some authors (Veale, 1993) argue that a separate syndrome of "primary obsessional slowness" proposed by Rachman (1974) may not be needed. Rachman (1974) described a syndrome where other obsessions were not present nor the slowness was in response (secondary) to other obsessions found in OCD. Other authors (Veale, 1993; Ratnasuriya et al., 1991) suggest that there is a substrate of other obsessions in obsessional slowness, hence giving rise to the concept of "primary" and "secondary" obsessional slowness (Veale, 1993). Veale (1993) stated that most of the cases be-
longing to this syndrome suffer from OCD with secondary slowness. According to the author, in most of the cases of "primary obsessive slowness", slowness can often be reanalysed as part of avoidance of disorder, unmetiticousness and inexactness. Components of obsessional slowness are multiple, the excessive time spent is not just related to orderliness or meticulousness but usually a wide range of activities adopted by patient (Veale, 1993). In an attempt to find biological correlates of obsessional slowness, Hymas et al.(1991) studied basal ganglia pathology of 17 patients with obsessional slowness. All patients exhibited slowing in self-care and goal directed behaviour. All patients were shown to have soft signs, delay in brain pathology, neuropsychology or other, difficulty in carrying out two motor acts simultaneously, speech and gait abnormalities and general clumsiness. However, similar features were reported in adult patients with OCD (without slowness). So far no validation attempt either on brain pathology, neuropsychology or multivariate analysis has been able to delineate subgroup of slowness symptoms with in the syndrome of OCD. Hence, it appears more logical to organize classification around recognized phenomenon of OCD than to single out orderliness and meticulousness as separate syndrome.

In the index case, patient's compulsive rituals such as repeated checking for his wallet, combing and gazing in the mirror, and the peculiar way in which he walked contributed to his slowness. The obsessionality of these behaviours can not be doubted because they were regarded as absurd by the patient. Extreme slowness in bathing and passage of stool in clothes appears to be due to indecisiveness and procrastination. As proposed by Veale (1993), these behaviours can also be understood as avoidance strategies to decisiveness and quickness which are parts of the obsessive-compulsive spectrum.

Different authors (Veale,1993; Salkovsvskis and Kirk,1989) have advocated exposure (and response prevention) to inexactness and unmetiticousness and exposure to obsessional thoughts by audio-tape feed back as methods to overcome slowness. Cognitive work and supportive therapies have also been advocated as a part of the package of OCD (Salkovsvskis and Kirk, 1989), but these have not been tested specifically in the treatment of slowness. Poor motivation to comply with prompting and pacing appears to be the principal factor for failure of these strategies in the index case. With exposure, a reasonable degree of improvement was noted. Improvement was sustained over follow-up outside the hospital and it generalized to areas other than that of exposure (e.g. patient became continent), which emphasizes the effectiveness of this therapeutic strategy.

There is a need to examine the role of thyroid abnormality and thyroxine and serotonergic drugs as also observed by Hamlin et al., (1989) in obsessive slowness as observed in the index case.

The report supports Veale's (1993) position of viewing slowness as a phenomenon secondary to OCD. A careful behavioural analysis might indicate exact strategies required for treatment of such patients.

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