The man who lusted after Jesus Christ and Virgin Mary: A case report

Rui Qi Tan and Vanessa Wai Ling Mok

Abstract
We report a case of a geriatric male patient who presented with unique features of obsessive-compulsive disorder revolving around religious and sexual themes. Psychodynamic therapy, instead of the traditional choice of cognitive behavioural therapy, was successfully used in conjunction with pharmacotherapy, leading to an improvement in symptoms.

Keywords
Psychogeriatrics, psychotherapy, obsessive-compulsive disorder

Introduction
Obsessive-compulsive disorder (OCD) is a common psychiatric illness in Singapore, with a lifetime prevalence of 3.6%. It presents with either obsessions, compulsions or both. Obsessions are thoughts, urges or images that are recurrent, persistent and egodystonic. Compulsions are repetitive acts performed by an individual, often in response to an obsession, to reduce distress. The commonest theme of obsessions and compulsions locally is ordering (54%), while the prevalence of sexual or religious themes is unknown.1

Cognitive behavioural therapy (CBT), which involves exposure and response prevention, is commonly used in OCD treatment. Psychodynamic therapy focuses on object relations, which stem from early life experiences. Through revelation of unconscious content, it seeks to alleviate psychological conflicts.

We report a case of a geriatric male patient who presented with unique features of OCD revolving around religious and sexual themes. In view of the patient’s psychodynamic underpinnings to his presentation, psychodynamic therapy, instead of the traditional choice of CBT, was used in conjunction with pharmacotherapy to treat the patient successfully.

Case report
The 67-year-old male first presented to our psychiatric outpatient services in May 2017. For one month, he had intrusive sexual thoughts about strangers walking by him, which progressed to sexual thoughts about Jesus Christ and Virgin Mary. Ruminations about Virgin Mary included: “How big are her nipples? Would I like to suck them?” and thoughts about Jesus Christ encircled: “Maybe I could suck on his private parts?”. As a heterosexual, he felt especially distressed with the latter. He considered whether the Devil placed these thoughts into his mind in an attempt to break him from his Catholic faith. There were no associated compulsions. He did not have resultant changes in his sexual behaviour nor urges to touch strangers. These thoughts resulted in secondary low mood, interrupted sleep with early morning awakening, poorer appetite and 2 kg of weight loss. He lost interest in his hobbies. He stayed home to avoid strangers triggering sexual thoughts. He was conflicted over attending mass, feeling “unworthy” of church due to these thoughts but felt guilty for absenting himself. He felt life was meaningless and had fleeting passive suicidal thoughts.

The patient was the fourth of five children. His mother, who was his main disciplinarian and caregiver, was deeply religious. He had a strict Catholic upbringing, becoming pious overtime. His father was the main breadwinner of the family but was not financially savvy. He was largely ignored by his two older brothers and presumed that they did not want “this small fry to tag along”.

As sex was a taboo topic within his family, he wilfully concealed pornographic material from his family since puberty. He masturbated regularly to pornography, but stopped in his 40s, worried about his family discovering his “sin”. He...
described regaining “a sense of control” through abstinence. He only succumbed to his sexual desires while overseas by having sexual trysts with prostitutes, believing his family could not catch him. He was never attached and chose to remain single due to anxiety about “doing enough” for others.

He originally aspired to be a doctor. Failing to meet the admission criteria for medical school, he pursued a bachelor’s degree instead and eventually worked as an administrative executive. He perceived that his siblings were academically more superior, with careers far more respectable than his. He voluntarily resigned from his job in his 40s to be a full-time caregiver for his ailing parents. He has been living alone in his parents’ residence for the past four years after their demise.

He started developing various health issues in his 60s, which led to a gradual rise in anxiety levels preceding his current presentation.

He did not have personal or family history of psychiatric illnesses.

Systemic review was normal. His full blood count, liver, renal and thyroid function tests were unremarkable.

Based on the Diagnostic and Statistical Manual of Mental Disorders (5th edition), he was diagnosed with OCD, of moderate severity. Escitalopram, which was already started by a family physician prior to his first psychiatric consultation, was gradually uptitrated to 20 mg daily. The patient’s secondary depressive symptoms improved substantially after six weeks of pharmacotherapy, but he continued to have obsessional thoughts. In view of the prominent psychodynamic underpinnings in the sexual and religious themes of his obsessions, the decision was made to refer him for individual psychodynamic therapy to address his underlying intrapsychic conflicts, which were unlikely to resolve with pharmacotherapy alone.

His psychodynamic therapy sessions commenced in August 2017 and were conducted fortnightly for a year. Exploration of childhood experiences and object relations was done to increase his self-awareness and better understand influences of his past experiences on present behaviour. Upon completing psychotherapy, his obsessional thoughts and emotional distress reduced significantly. Escitalopram was eventually tapered down to 10 mg daily.

**Discussion**

Although symptoms of OCD are believed to be caused by a disruption of various neurotransmitter circuits, there may be underlying psychodynamic meanings to them. According to psychodynamic theories, obsessions and compulsions are signs of an unconscious internal conflict that the patient has trouble processing. To suppress this internal conflict, defence mechanisms are mobilised – predominantly isolation of affect in obsessions and undoing in compulsions.

We hypothesise that our patient’s early life experiences of being outperformed and ignored by his brothers resulted in poor self-esteem. A highly religious upbringing instilled in him a strict moral code, which he probably followed to acquire parental validation. This was done at the expense of suppressing impulses perceived to be “immoral”, including sexual desires. Health-related anxieties in advancing age led to a perceived loss of control over his life circumstances. Coupled with increased loneliness and reduced authoritative presence after his parents’ demise, these triggered the resurfacing of undesirable sexual impulses, which were disowned and manifested as ego-dystonic obsessions. We believe that sexual obsessions were cast upon religious figures due to underlying rage at authoritative figures, whom he experienced as unattuned to his needs.

This formulation was consistent with transference and counter-transference elements that arose during psychotherapy. Dressed in formal attire, he was a “perfect” patient – always punctual, and rarely challenging boundaries or interpretations made by the therapist despite his reservations. This is likely driven by his desire to obtain approval from his therapist, who was perceived as the authoritative figure. Highlighting this pattern of relation to him increased his awareness of what was described as “pathological altruism”, and his defences against feelings of “aggression”, which surfaced whenever his needs were overlooked by others.

Although CBT is traditionally the therapy of choice for OCD treatment, we opted for psychodynamic therapy based on the formulation of our patient. Our literature review found another local case report, which demonstrated the successful treatment of a teenager with OCD through the use of psychodynamic therapy. Similarly, there were significant psychodynamic meanings behind his symptomatology. Another reason why CBT was deemed less favourable is due to the absence of compulsions in the patient’s presentation. Given that response prevention is a major component of CBT, the benefit it offers in this case is limited.

Of note, our patient is part of the geriatric population, in which the use of psychodynamic therapy as a psychiatric treatment is not common practice. Freud stated that “near or above the age of 50 the elasticity of the mental processes on which the treatment depends, is as a rule lacking – old people are no longer educable”.

However, analytical attitudes have been changing gradually. Greater emphasis should be placed on continuing emotional development in the elderly for a more holistic approach towards ageing. There has been emerging evidence supporting the use of psychodynamic therapy in the elderly, with results as successful as its use in the younger population.

Undeniably, there are limitations in using psychodynamic therapy in the treatment of elderly patients with OCD. Firstly, a strong therapeutic alliance and commitment to therapy are crucial elements in ensuring a positive outcome. Our patient also demonstrated good insight, curiosity about his symptomatology and openness towards working with a therapist. This mode of therapy is likely more befitting of patients with a similar profile. Secondly, language barriers in the elderly may impede the use of such therapy locally. Thirdly, therapy sessions are conducted frequently over a prolonged duration within hospital grounds. As such, it is not ideal for elderly patients with ambulatory difficulties, as accessibility to this service poses as an obstacle instead.

**Conclusions**

Psychodynamic undercurrents may contribute to OCD symptomatology. Treatment with psychodynamic therapy appears to be effective, even in the elderly. Being one of the few institutions locally that offer psychodynamic therapy services, we hope to demonstrate through this case report the crucial role
that this mode of therapy plays in providing a more holistic approach towards attaining mental well-being in the aged and would like to encourage further development in this area.

**Authors' contributions**

Dr Tan Rui Qi wrote the first draft of the manuscript. All authors reviewed and edited the manuscript and approved the final version of the manuscript.

**Availability of data and materials**

Data sharing is not applicable to this article as no datasets were generated or analysed.

**Declaration of conflicting interests**

The authors declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

**Informed consent**

Written informed consent was obtained from the patient for his anonymised information to be published in this article.

**Ethical approval**

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**ORCID iD**

Rui Qi Tan https://orcid.org/0000-0002-6653-2208

**References**

1. Subramaniam M, Abdin E, Vaingankar J, et al. Obsessive-compulsive disorder in Singapore: prevalence, comorbidity, quality of life and social support. *Ann Acad Med Singapore* 2020; 49: 15–25.

2. McWilliams N. *Psychoanalytic diagnosis: understanding personality structure in the clinical process*. 2nd ed. New York: Guilford Press, 2011, p.426.

3. Lim CS and Wuan KM. A case of obsessive-compulsive disorder precipitated by military service. *ASEAN J Psychiatry* 2018; 19: 1–3.

4. Freud S. *On psychotherapy*. Standard edition, vol. 7. London: Hogarth, 1953, pp.249–256.

5. Evans S and Garner J. *Talking over the years: individual psychotherapy in the second half of life*. Hove: Brunner-Routledge, 2004, p.290.

6. Leigh R and Varghese F. Psychodynamic psychotherapy with the elderly. *J Psychiatr Pract* 2001; 7: 229–237.