Case Report

Cognitive Therapy of Obsessive Compulsive Disorder with Chronic Tic Disorder

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ABSTRACT

The gold standard of therapy for obsessive compulsive disorder, exposure with response prevention, may not be suitable to obsessional sub-type. Live exposure is not possible and response prevention is difficult. These obsessions (sexual, religious or aggressive) are repugnant and resisted. Negative attitude against obsessions leads to treatment refusal or dropout from therapy. In Cognitive therapy (CT) these attitudes can be corrected and exposure can be administered in the form of behavioral experiments (using behavioral tasks to change the dysfunctional attitudes). Such a case is treated with CT, weaned off medications and remains improved at 9 months.

Key words: Cognitive behavior therapy, cognitive therapy, obsessive compulsive disorder

INTRODUCTION

Pure obsessional type of obsessive compulsive disorder (OCD) is thought as a sub-type of this disorder.(1) Exposure with response prevention (ERP), a gold standard,(2) may not be suitable for OCD with pure obsessionals (having mainly obsessions, mental compulsions and obsessive ruminations). This appears due to an inability to do live exposure and difficulty in response prevention. In these cases most obsessions are sexual, religious or aggressive and inherently highly repugnant and resisted. Patients’ strong negative attitude against these obsessions and apprehension about allowing those thoughts without opposing them may lead to treatment refusal. In cognitive therapy where strong attitudes which work against therapy can be corrected and ERP can be administered in the form of behavioral experiments(3) to change the dysfunctional schema like over importance of thought and need to control thoughts.(4)

CASE REPORT

On 2-9-2009, 27-year-old male, who got graduation in M Sc. in computer science, employed regularly, presented with complaint of purposefully going into toilets or rooms (to avoid people noticing) and talking to self while tensing his body since 2 years but increase markedly over few months. These episodes occurred several times a day and each episode lasted for 10 min to 2 h. Self-talk varied from faint muttering to loud yelling. During these times he was making movements forcefully, like, blinking, opening eye lids, and deviating eye balls; tensing scalp, abdomen, limb and chest muscles. Sometimes he pressed, banged or lifted his breast area, mentally visualizing his chest to be of male (not having gynecomastia). At times he held his breath and increased the pressure in the chest.

Patient had several unacceptable sexual thoughts about relatives with sexual arousal, aggressive images (dead bodies of relatives), doubts about appearance...
and acceptance from friends and relatives; and need to remember perfectly. When these thoughts appeared he was consoling and convincing himself by self-assurances, rationalizations, analyzing them till his mind was accepting his view about those issues. He tried to recall information till he is satisfied. It was a struggle to convince own mind against intruding thoughts, which were unacceptable. During this struggle, the self-talk (spoke the content of thoughts loudly) and tensing the body accompanied.

During adolescence he was treated briefly for washing compulsions and improved. He had intermittent concerns over balding, shape of his chin, having gynecomastia, getting swine flu or scrotal cancer over a period of few months. He had anankastic and borderline personality traits.

A diagnosis of OCD with chronic tic disorder with anankastic and borderline traits was made. Fluvoxamine and clomipramine were titrated to 200 mg and 100 mg respectively and talking to self-tics and body tensing were improved. Addition of risperidone did not benefit him. His residual symptoms were preoccupation with gynecomastia, complex tics, several obsessions, mental compulsions and ruminations (but without talking to self). He was referred to a qualified psychologist to undergo cognitive behavior therapy (CBT) and in 20 sessions preoccupations with breast shape and tics improved but obsessions persisted. Perusal of his past CBT treatment notes revealed that therapy had focused on preoccupation on gynecomastia and tics (habit reversal) but obsessions remained untouched.

During follow-up, after 2 years, author offered him cognitive therapy (CT) for his persisting obsessions and patient consented. Main schematic beliefs were need to control and over importance of thoughts (moral thought action fusion). He believed that just presence of sexual thought made him a bad person and failure to control his mind might lead to overt sexual (womanizer) behavior. He aspired for mental purity. Unless he recalled information perfectly, he thought, he will not retain information usefully (low cognitive confidence). Initially patient was reluctant to allow sexual thoughts freely for 1 day and observe for any change in his behavior. Gradually he was more confident and stopped mental compulsions in response to sexual thoughts. He was told to look at ladies (he was avoiding) or imagine and masturbate as much as he wanted lead to reduction in avoidance of sexual issues. He was told to stop doing repeated recall of information for 1 day and see any deterioration in his memory or functioning. He learnt that there was no need to take care of his memory and those compulsions improved. He wanted an ideal friendship in every friend in every occasion. This splitting or polarized thinking was corrected. At the end of therapy he told that friendship pricks him only once in ten times compared to past.

Surgical opinion confirmed the presence of grade II true gynecomastia. Patient decided to undergo surgery at a later date for the need of money. With this new hope his concern and obsessions over gynecomastia improved. Along with improvement in OCD, tics and muscle tensing also improved. Over 2 months (with 10 sessions of therapy) medications were tapered and stopped and patient reported good improvement and was quite happy. Monthly three more booster sessions were given and patient is maintaining improvement.

**DISCUSSION**

This patient had several OCD spectrum conditions which makes this case more interesting. This patient had true gynecomastia which was overlooked in the past. But he also had marked preoccupation with it and it was a content of obsession. Differentiation of complex tics and compulsions may be difficult (stretching of body parts in this case). Entanglement of compulsions and tics is noted in the literature.[5] In the past patient was treated with CBT for tics and concern with gynecomastia by another therapist. Author did CT for obsessions as earlier therapy did not improve obsessions.

In OCD mental intrusions are catastrophized (in panic disorder, symptoms of anxiety are catastrophized) and interpreted as bad, mad or dangerous.[3] The CT aims at normalizing these appraisals and consequently ends the compulsions, ruminations and avoidance.

Problem in this type of patients can be conceptualized as abnormality in metacognitive beliefs (beliefs about thoughts and other mental processes). Correction of these beliefs is also called metacognitive therapy, a type of CT.[6]

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