The International Journal of Indian Psychology
ISSN 2348-5396 (Online) | ISSN: 2349-3429 (Print)
Volume 12, Issue 3, July- September, 2024
DIP: 18.01.258.20241203, DOI: 10.25215/1203.258
https://www.ijip.in

Case Report

Psychotherapeutic Management of Sensorimotor OCD Using an Eclectic Approach: A Case Report

Sanskriti Singh[1]*

ABSTRACT

Neither DSM-5 nor ICD-11 include sensory sensations in their description of obsessions. The only terms included are thoughts, urges/impulses and images. This case reports detailed management of sensorimotor obsessions in a 29-year-old male using Cognitive Behaviour Therapy, Exposure and Response Prevention, Acceptance and Commitment Therapy, Dialectical Behaviour Therapy, Narrative Therapy and Existential therapy.

Keywords: *Sensorimotor OCD, Obsessions, OCD, OCD treatment, ERP, eclectic therapy*

Obsessive-compulsive disorder (OCD) is a neuropsychiatric disorder associated with significant impairment and a lifetime prevalence of 1% to 3%; however, it is often missed in primary care settings and frequently undertreated. (1) In many individuals, seemingly disparate sensory-motor symptoms can be conceptualized as part and parcel of OCD. These phenomena have received less attention than obsessions and compulsions, but are nonetheless important in the development, maintenance, phenomenology, and treatment of the disease. (2)

CLINICAL CASE

A 29-year-old post graduate male, currently employed in an MNC, recently married, presented to the OPD with complaints of a "languishing" feeling, existential anxiety, reduced interest in work and pleasure and a nagging preoccupation with swallowing his saliva. He reported that he first had this problem when he was in the 10th standard. At that time, he had started yoga and meditation. He started focusing on swallowing his saliva while meditating and it bothered him for a few days before it got better on its own. This is the second episode of unwanted focus on bodily processes.

He reported that as soon as he's free, his mind starts anticipating it. It brings the thought, "How long have you not thought about it?" When he has this thought, he suddenly feels conscious and that is when saliva starts accumulating in his mouth. He swallows it consciously and then this process becomes a loop. He does not report feeling any significant fear about this but he doesn't feel relaxed either. He shared that it's affecting his calmness and peace of mind. He feels helpless and frustrated as he is not able to consciously get out of it.

[1]Research Scholar
*Corresponding Author

Received: March 14, 2024; Revision Received: September 23, 2024; Accepted: September 27, 2024

He shared that it's his first thought on waking up and last thought before sleeping. He got married a year ago and has not shared it with his wife till now and is afraid that telling her might "trap her" in the same problem. He continues with his routine but reports feeling demotivated and not getting any pleasure or a sense of accomplishment. Family history revealed chronic insomnia and significant health anxiety in mother. He obtained a score of 23 on Y-BOCS revealing moderate obsessive features and was diagnosed with obsessive compulsive disorder, predominantly obsessions. Moderate depressive features, secondary to OCD were also found.

PSYCHOTHERAPEUTIC MANAGEMENT

Initial phase of psychotherapy started with psycho-education about the symptoms, causes, prevalence and treatment of OCD. Different types of obsessions like thoughts, images, impulses and sensorimotor obsessions were discussed. The OCD cycle was explained. Patient was taught about prominent cognitive distortions that play a role in maintaining OCD like secondary anxiety, hypervigilance, attributing meaning to events, and catastrophization.

The concept of secondary anxiety and how it feeds in to the primary anxiety was discussed. The source of these obsessions is anxiety and when the patient worries about it, it maintains the problem. Repeatedly checking to see if he is swallowing his saliva or not makes him more anxious and also intensifies the problem. Patient was also asked about what the problem signifies in his life. It revealed that the patient feels "caged" in this problem and even scared that he will "trap" someone else in it. He was explained how he could be attaching more meaning to it than required. He was explained the concept of attributing meaning to harmless events. He was interviewed to reveal positive events, feelings and experiences in the past few months in order to gather evidence against catastrophic thinking with regard to his symptoms. Socratic questioning was used and also taught to the patient.

Exposure and response prevention was started in the middle phase of psychotherapy. This was done after psycho-education about concepts like habituation, reinforcement, punishment and paradoxical intention. It was also explained in detail how exposure works. The patient revealed fear of intrusive focus on saliva swallowing. He was encouraged to place reminders around him through "post it" notes to create habituation with such intrusion. He was also asked to write a fear script about saliva swallowing, exaggerating the negative impact of this problem on his life. Following this, he was asked to record it and engage in audio exposure for 15 minutes every day.

When the patient reported reduction in anxiety with the fear script, he was told to engage in mindfulness meditation for 20-30 minutes every day and focus on all bodily sensations from top to toe like blinking, breathing, heart beating, etc. He was suggested to spend more time focussing on saliva swallowing. However, other bodily sensations were also focussed on in order to prevent relapse of sensorimotor obsessions with a different theme. This sensation exposure exercise was continued for the rest of the therapy.

In the end phase of psychotherapy, he was encouraged to share the problem with his wife and then few close friends. Cognitive distortions and fears associated with the same were challenged using socratic questioning. The results of the exercise were discussed and used to highlight the difference between imagined and real outcomes.

Patient was encouraged to introspect how his life would be if he did not have this problem. He was suggested to focus on his goals and values despite the problem. Collaboratively, a list of goals was made and it was decided that he would start to work on them gradually.

Patient was asked what "true acceptance" of the problem would look like in his life. He shared that if he accepted the problem, he would talk about it freely. He would be able to focus on his work. He also shared that he would meet his friends more often. He was encouraged to do these things gradually and that would improve his acceptance of the problem. He also had a migraine problem and parallels were drawn about his acceptance of a painful condition like migraine and a relatively harmless obsession.

Narrative therapy life timeline exercise was conducted to help patient integrate life experiences and to create a realization that the impact of sensorimotor obsessions in the bigger picture of his life is minimal. The exercise was also used to create awareness of patient's values, beliefs and choices. This information was used to find purpose and meaning in life. Therapy assignments to create meaningful experiences and to reminisce similar past experiences were also done.

Follow up after 3 months revealed that only 10-20% of the problem had remained. Patient shared that he is able to work along with it and not fear it. Acceptance of the problem was again discussed in this light. All learnings were consolidated before therapy termination.

DISCUSSION

Cognitive behavioral therapy (CBT) with exposure and response prevention (ExRP) is the gold standard treatment intervention for OCD (3) However, treatment of OCD using an eclectic approach with ERP along with the techniques of psychological flexibility and committed action from Acceptance and Commitment Therapy and mindfulness and radical acceptance from Dialectical Behaviour Therapy may prove to be beneficial.

REFERENCES

1. Hirschtritt ME, Bloch MH, Mathews CA. Obsessive-Compulsive Disorder: Advances in Diagnosis and Treatment. JAMA. 2017;317(13):1358–1367. doi:10.1001/jama.2017.2200
2. Stevens, K. P., Hoffman, J., & Hsia, C. (1998). Sensory-Motor Aspects of Obsessive-Compulsive Disorder. CNS Spectrums, 3(7), 31–36. doi:10.1017/S1092852900006155
3. Koran LM, Hanna GL, Hollander E, Nestadt G, Simpson HB, American Psychiatric Association. Practice guideline for the treatment of patients with obsessive-compulsive disorder. Am J Psychiatry. (2007) 164:5–53.

Acknowledgment

The author(s) appreciates all those who participated in the study and helped to facilitate the research process.

Conflict of Interest

The author(s) declared no conflict of interest.

How to cite this article: Singh, S. (2024). Psychotherapeutic Management of Sensorimotor OCD Using an Eclectic Approach: A Case Report. *International Journal of Indian Psychology*, *12*(3), 2679-2681. DIP:18.01.258.20241203, DOI:10.25215/1203.258