Comorbidities/ complex cases
Obsessive compulsive disorder

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Intrusions/ obsessions we all have...

- Impulse to hit or hurt someone
- Impulse to yell curses in a silent church
- Impulse to destroy something
- Impulse to cause a collision while driving
- Impulse to push other people away from a crowd or a row
- Impulse to jump of the roof of a tall building, mountain or cliff
- Impulse to jump from the platform when a train arrives
- Impulse to drop a baby

- Etc.. etc. etc.
Obsessions

Fear of germs
Thinking that something bad is going to happen to you

Thinking something bad is going to happen to someone you love
Thinking that you might harm someone even though you don’t want to

I am not obsessive
I am not obsessive
I am not obsessive
I am not OBSESSIVE
I am not OBSESSIVE
I am NOT OBSESSIVE
I am NOT OBSESSIVE
I am not obsessive
Compulsions
The OCD cycle consists of the following steps:

1. **Relief**
2. **Obsessions**
3. **Compulsions**
4. **Anxiety**
New specification:

TICRELATED OCD
Red columns: ‘OCD-like’ Repetitive Behaviours; blue columns: ‘tic-like’ Repetitive Behaviours * p<0.0001. (Worbe et al, 2010)
<table>
<thead>
<tr>
<th></th>
<th>Pure OCS without tics</th>
<th>OCS + tics/ TS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Starting age</strong></td>
<td>Often &gt;18 yrs</td>
<td>Around 14 years</td>
</tr>
<tr>
<td><strong>Sex</strong></td>
<td>Male ≤ Female</td>
<td>More male</td>
</tr>
<tr>
<td><strong>Just right perceptions before OCS</strong></td>
<td>+</td>
<td>+++</td>
</tr>
<tr>
<td><strong>Mental Play</strong></td>
<td>+</td>
<td>+++</td>
</tr>
<tr>
<td><strong>Touching, ticking, rubbing</strong></td>
<td>+</td>
<td>+++</td>
</tr>
<tr>
<td><strong>Accompanying fear</strong></td>
<td>+++</td>
<td>+</td>
</tr>
<tr>
<td><strong>Goal oriented OCD</strong></td>
<td>+++</td>
<td>+</td>
</tr>
<tr>
<td><strong>Sexual, religious, aggressive obsessions</strong></td>
<td>++</td>
<td>+++</td>
</tr>
<tr>
<td><strong>Severity of OCS</strong></td>
<td>=</td>
<td>=</td>
</tr>
<tr>
<td><strong>Effect on treatment</strong></td>
<td>= SSRI</td>
<td>= SSRI + dopamine antagonist</td>
</tr>
</tbody>
</table>

• Comorbid OCD does not have a negative impact on BT outcomes (McGuire et al., 2014)

• Comorbid tics do not interfere with CBT for OCD (Conelea et al., 2014; Himle et al., 2003)

• However, lower treatment response on medical treatment (either 2 trials of SSRI, or 1 trial of SSRI and 1 trial of clomipramine) for patients with OCTD (Benatti et al., 2021)

• Start with OCD or tic treatment?? Depending on question for help
  • If obsessions/ anxiety are a barrier for tic treatment, start with OCD treatment (Bloch & Storch, 2015)
Treatment options

• Both ERP and HRT are suitable for treating TS with comorbid OCD

• Slight preference for ERP because of comparability of techniques (Andrén et al., 2019; Conelea et al., 2014; Verdellen, et al., 2004)
<table>
<thead>
<tr>
<th></th>
<th>TS</th>
<th>OCD</th>
<th>Ticrelated OCD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Response prevention of</td>
<td>Tic</td>
<td>Compulsion</td>
<td>Ticrelated OCD</td>
</tr>
<tr>
<td>the tic</td>
<td></td>
<td></td>
<td>symptoms</td>
</tr>
<tr>
<td>Exposure on</td>
<td>Premonitory</td>
<td>Anxiety</td>
<td>Just right</td>
</tr>
<tr>
<td></td>
<td>urges</td>
<td></td>
<td>feeling</td>
</tr>
</tbody>
</table>
Clinical case

• Mandy, 14 yrs old
• Motor tics: head shaking, touching tics, tapping on doors
• Vocal tics: huh sound
• In the past, there have been several other tics
• Bed ritual
• Putting things down several times – cause broken phones, glassware etc.
• Sometimes premonitory urge, sometimes anxiety/ obsession (“if I don’t do this, I will see someone vomiting”)
• Avoidance of places where people might vomit
<table>
<thead>
<tr>
<th>Tics</th>
<th>Tic-related OCD</th>
<th>OCD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Head shaking, huh sound</td>
<td>Touching door 3x, putting glass down 3x</td>
<td>Bed ritual, if I don’t do this, someone will vomit</td>
</tr>
<tr>
<td>Itchy feeling in neck/throat</td>
<td>Just not right feeling/ strange feeling in fingers</td>
<td>Anxiety</td>
</tr>
</tbody>
</table>
Treatment options

• First step: find out what are tics and what is OCD
• If not clear: do ERP as a diagnostic measure
• Start with what is most bothersome
  • ERP on tics
  • ERP on ticrelated OCD
  • ERP on OCD
  • Exposure in vivo on avoidance behaviour
Thank you for your attention!

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Using Catalepsy in Functional Tics

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Catalepsy induction

- Theory/rationale
- Application in functional tics
- Video demonstration
Catalepsy

- State of tonic immobility, freeze response
- Muscular rigidity
- Fixed posture
- Decreased sensitivity to pain
- Can be intentional induced

Example:
- Living statues
Catalepsy in animals

• Defense mechanism in both human and animals
• “Totstellreflex”: tonic immobility

https://youtu.be/SMZDieZoing
Catalepsy in people

- Originally used to help patients get into a hypnotic state (Sacerdote, 1970)

- Can be induced in the body, e.g. arms, legs, trunk, shoulders

- Effective in conversion disorder- motor type (e.g. paresis, paralysis, coordination problems, tremors, uncontrolled movements etc) (Moene et al., 2003)

- Effective in functional tics?
Catalepsy Induction

How to do it?

• Psychoeduction: “confuse the muscles”

• Start with catalepsy in the arm

• Push & pull fingers at the same time around different body parts

• Give lots of suggestions of what people might experience
Catalepsy Induction

• Patient does not have to do anything, just let it happen. If needed: distract

• Describe what you feel in the arm (first signs of resistance)

• Stiffness/deaf feeling will appear in the arm/feeling of a dissociated arm

• Test by pushing the arm down gently, if it bounces back in the original position, the (first signs of) catalepsy is there

• Cotherapist: invite a family member to learn how to do this

• Practice at home!! 5-10 times a day
Catalepsy Induction

• Next sessions: if needed catalepsy in other body parts
  • Legs
  • Shoulders
  • Total body catalepsy

• Ask patient to concentrate on the feeling of catalepsy to speed up the process

• In the end thinking of this feeling will be enough to induce the catalepsy

• Practice cataleptic state while walking/writing etc.
  • First a “robot walk”
  • Shape this into more normal movements
Background information


• Catalepsy is currently researched in functional neurological symptoms, in combination with hypnosis (N=64; Tibben et al., in preparation)

• Dutch manual available (Hoogduin et al., 2017)
Video demonstration
Thank you for your attention!

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