

Staring OCD Treatment: A Clinical Case Study

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Abstract

This is a case study of staring obsessive compulsive disorder in 30-year-old male patient who underwent selective serotonin reuptake inhibitor for being diagnosed with clinical depression and general anxiety disorder.

Key Words: obsessive compulsive disorder; clinical depression; selective serotonin reuptake inhibitor; insomnia; general anxiety disorder

Introduction

Obsessive Compulsive Disorder (OCD) is treated with the same medication that is used to treat depression. Staring OCD/moral OCD was found in patients who used to have depression. Another theory that staring OCD have to do with temporomandibular joint malfunction. Staring OCD can be central vision (i.e., face to face) or peripheral vision (i.e. person standing or sitting next to). Staring OCD is done by focusing on males, females, children, and animals front or back side. This disorder is turettic in nature and it happens in cycles. The mind has intrusive thoughts and anxiety preceding the staring in order to humiliate the patient which cause the patients to isolate themselves or to wear sunglasses to avoid people looking into the eyes. The staring OCD patients have social anxiety that lead to avoid working with people in normal setting and trying to put some kind of obstacle in the visual field to avoid looking to people in the wrong way. The stress about losing reputation or not be accepted by the society or considered "weird or pervert". Staring OCD get less worse with having a pattern and sometimes the patients lose their patterns due to having staring OCD or even lose their jobs. Many patients undergo cognitive behavioral therapy which uses Exposure and Response Prevention (ERP). Some experts recommend to have more exposure to uncomfortable situations in order to reduce the anxiety and others suggest to forget having staring OCD which both proven not to be working. Others suggest to have a support group of staring OCD patients which makes the patient remember their dilemma and get worse types of staring OCD or OCD happens in general.

A Clinical Case Study

30-year-old male patients who suffered from staring OCD in the age 15 with a history of a 4 months of depression at the age of 11. The patient showed early signs of OCD at the age 9 when he used to walk on certain patterns on the carpet. The first experience of staring OCD continued for two months then disappeared. Then the patient grows up and went for college and he suffered for 1 and a half year from staring OCD. The disorder came and go without the patient knowing he has it. He grows up and find a job and the disorder came again and stayed with him for 5 years. This time, the patient looked for a professional help and he spoke with a psychologist which used psychoanalysis and freudian method which did not help. The patient suffered from depression as a result of being rejected. The patient developed General Anxiety Disorder (GAD) which caused the patient insomnia. The patient suffered involuntary hand movements when the hands are moving for some time. The patient went to his psychiatrist and the patient was diagnosed with clinical depression and General Anxiety Disorder (GAD). The patient was put on a six-months course of Selective Serotonin Reuptake Inhibitor (SSRI) which does not cause insomnia called Escitalopram 10 mg once daily in the morning for the depression and the GAD (i.e., it might have an opposite reaction). Quetiapine Fumarate 25 mg at night for insomnia. Staring OCD became less aggressive with SSRI and the SSRI reduced the patient anxiety and depression to a low level. The patient had a brain MRI scan before using the SSRI course which showed a normal brain. In the final day of the SSRI course, the patient underwent another brain MRI which showed slight enlargement in the basal ganglia (i.e., head of the caudate nucleus, putamen, and globus pallidus). A pre-treatment and post-treatment MRI of the brain was done to check for any changes in the size of the basal ganglia as seen in (Figure 1 and Table 1).

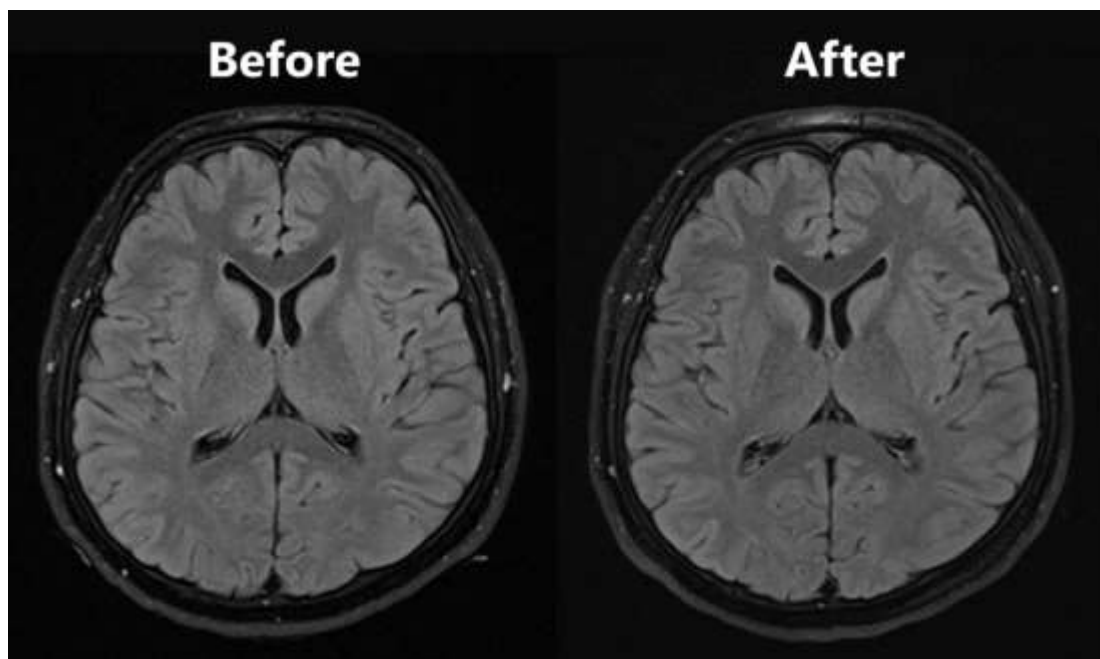


Figure 1: An axial FLAIR MRI sequence was done before and after the SSRI treatment which shows a normal brain on both images and a slight enlargement in the basal ganglia nuclei on the image on the right side (i.e., after the treatment). Note: Thalamus is not part of the basal ganglia nuclei.

Measurments Pre-Treatment and Post-Treatment

	Pre-Treatment Measurments	Post-Treatment Measurments
Parts	Measurments in mm	Measurments in mm
Right Lentiform N. Width	13.11	13.32
Right Lentiform N. Length	39.26	40.22
Right Head of Caudate N. Width	21.12	22.66
Right Head of Caudate N. Length	11.09	11.55
Left Head of Caudate N. Width	21.43	22.65
Left Head of Caudate N. Length	9.62	11.21
Left Lentiform N. Width	11.32	12.39
Left Lentiform N. Length	35.60	36.20

Table 1. Basal ganglia measurments before the treatment.

SSRI is responsible for enlarging the basal ganglia in depressed patients. As well, the patient suffered from hematemesis due to consuming the SSRI (i.e. Escitalopram 10 mg once daily) and the patient suffered a gastric ulcer due having the SSRI medication. The patient was not aware that he is *H. pylori* positive which made the stomach mucosa weak. The patient was prescribed antacid non constipating (moxal) 20 ml after a meal which did not help either with the Escitalopram. The antacid did not help much with the ulcer, so the patient was prescribed omeprazole 20 mg once daily before per os before any meal.

As a side effect of the Quetiapine Fumarate and SSRI, the patient suffered from exhaustive dreamings and nightmares. Quetiapine is more associated with dreaming, but SSRI increase REM sleeping. The patient described dreaming every night until the patient felt exhausted from dreaming. The patient symptoms of staring OCD reduced significantly with new people who are not aware he suffers from staring OCD. The SSRI reduce the levels of staring OCD to some degree. The patient was put on SSRI for 6 months and another 6 months for maintenance. The patient after one year stopped the SSRI and his staring OCD symptoms reduced significantly.

Discussion

Tourette Syndrome is associated as well with depression like the relation between staring OCD and depression [1]. Tourette's tics can be treated with the use of fluphenazine, haloperidol (Haldol), risperidone (Risperdal), and pimozide (Orap). Involuntary repetitive movements and weight gain are possible side effects. Staring OCD could be tourettic staring, but it is confused due to not understanding it's nature. Tourette Syndrome is treated by medications that decrease the level of dopamine, meanwhile, the SSRI increase the level of serotonin in the brain. Both medications are based on the chemical imbalance theory in the brain which is questioned theory [2].

Staring OCD/tourettic staring is not treatable at the moment due to the fact that we do not understand what causes these conditions and the pathophysiology of this disorder. It is known that patients who have staring OCD/tourettic staring have a history of depression. It could be that this staring which happens in patients with history of depression have a type of tourette syndrome. There are two words in psychiatry; mania and obsession which they vary significantly see (Table 2).

Difference	Mania	Obsession
Nature of Emotion	Impulsive, risk taking, self esteem, and less need for sleep.	Anxiety and emotional discomfort.
Duration of Symptoms	Last a week then relapse	It stays longer
Focus of Thoughts	Grandiose, quick slutations, and impulsive ideas with distractions.	Reptitive, intrusive, and difficult to control.
Associated Behaviours	Impulsive sexual behaviours, substance abuse, and seeking thrill.	Mitigated by compulsions.

Table 2: The differences between mania and obsession.

From the previous table, it is clear that mania is different from obsession. But obsession in case of staring is not clear is it tourrotic or OCD in origin? Based on the pattern of staring OCD which sometimes be so intrusive and can't be stopped and sometimes it disappears to a certain degree.

This could be tested by checking the levels of hormones or neurotransmitters which could reveal any increase or decrease in a hormone or group of hormones which could explain having the ups and downs. OCD is characterised by high testosterone level. The 4 androgenic hormones (i.e., dehydroepiandrosterone sulphate (DHEAS), dehydroepiandrosterone (DHEA), androstenedione (A), and testosterone (T)) could be measured in the ups and downs of the staring OCD. The issue is that testosterone level shot up the highest level in the morning.

Since Tourette syndrome affects males more than females, tics become noticable with puberty in males due to surge of testosterone, and testosterone influences dopamine which might affect movement control which is still in ongoing research. The patient used to have issues in controlling his hands positions and jerky movement of the hands. This could lead to classify immoral staring as touretic staring. OCD is co-

occurring condition with tourette syndrome. And all mental disorders are called disorders, not diseases because it has a little bit of other mental disorders spectrums.

Conclusion

SSRI could reduce staring OCD to some degree, since it is a byproduct of depression. Staring OCD could be touretic in nature which needs to be studied further. Prolonged use of SSRI might increase the size of the basal ganglia nuclei. It is recommended to do six months of SSRI then follow it with maintenance for another 6 months based on the patient's condition.

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