CASE REPORT

INNOVATIVE TREATMENT OF A RARE EXAGGERATED OBSESSIVE-COMPULSIVE REACTION TO SMELL

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Abstract

Objective: **This case report highlights about a patient with OCD (Obsessive-Compulsive Disorder) patient who presented with exaggerated compulsions related to bad smell.** ***Methods:*** **We report a case of a cleaner who encountered bad odors and responded with compulsive showering and wearing fresh clothes. His disorder is differentially diagnosed with similarities and differences between his disorder and that of olfactory reference syndrome, bromidrophobia and obsessive disgust to smell.** ***Results:*** **The treatment of choice for OCD is exposure and prevention therapy (EPT). We started the treatment with cognitive restructuring combined with our innovative spiritually oriented mindfulness and acceptance therapy. And to avoid the shortcoming of EPT of excessive anxiety to full-blown exposure and prevention, we have introduced novel adaptations that rendered our therapy to be more of the classical reciprocal inhibition and the gradual systematic desensitization techniques of Wolpe than the straight forward EPT. The reciprocal inhibition was presented by asking the patient to smell a rotten fish in a plastic bag and whenever his anxiety became unbearable the bag was closed and he inhaled the opposite fragrance of sprayed perfume while relaxing and breathing abdominally. Similar to systematic desensitization therapy, we repeated the whole process but gradually increased the time of smelling the rotten fish before enjoying its opposite fragrance. His improvement was dramatic, observed from the first session. After 4 sessions, he resumed his job and had no relapse, but he carried a bottle of his preferred perfume to counteract the bad smell.** ***Conclusion:*** **OCD reaction to smell may respond well with only cognitive-behaviour therapy.** ***ASEAN Journal of Psychiatry, Vol. 14 (1); January – June 2013: XX XX.***

Introduction

OCD is classified by the DSM-1V as an anxiety disorder characterized by recurrent disturbing thoughts and/or repetitive, ritualized behaviors that the person feels driven to perform. For a long time, psychiatrists and mental health workers considered OCD an incurable chronic disorder. This pessimistic belief was however positively changed with the introduction of behavior therapy and antidepressants with serotonin reuptake inhibiting properties such as clomipramine and fluoxetine. The influence these drugs in reducing the symptoms of OCD have been established by experimental studies comparing patients taking the active drugs with patients on placebo [1]. On the other hand, it was found that atypical antipsychotic drugs can exacerbate the symptoms of OCD patients with comorbidity. This was verified by Atul Khullar and his colleagues in a case study in which quetiapine increased obsessive compulsive symptoms (OCS) in an OCD patient suffering from other disorders [2]. Another disadvantage

of medication treatment of OCD, is the very high relapse rate when the drugs are discontinued. On the contrary, behavior therapy by exposure and prevention was found to have long-lasting benefits [2].

Case report

We report a 43-year-old Indian man who worked as a cleaner in Hospital Kuala Lumpur Municipality (Dewan Bandar Kuala Lumpur) presented with bad odors and responded with compulsive showering and wearing fresh clothes. He was referred to me by his psychiatrist for the treatment of an obsessive-compulsive disorder related to bad smell. His main complaint was compulsive showering and wearing fresh clothes in response to the offensive smell of dead rats or other stink he encountered in his work. Malaysia is a warm humid country, so it is not uncommon for Malaysians to take showers during their lunch hour. The patient used to come to work with a bag of clean clothes and engaged in his compulsive rituals whenever he encountered an offensive odor. However, all kinds of non-smelly trash and dirt did not bother him even if it looked disgusting to other cleaners. The root of his disorder seems to have started in his childhood. His mother, who was over-sensitive to the bad smell of fish used to express her disgust in dramatic ways and she used to ask him as a little boy to quickly wash his hands to deodorize the smell of fish. Smell of rotten fish became one of his most abhorrent odors.

Compulsive reaction to smell is generally diagnosed as OCD, but showering and changing into clean clothes is indeed a rare exaggerated response to a bad smell. Repetitive showering is often observed in the OCD known as olfactory reference syndrome (ORS). However, in ORC the patient's cleansing compulsions are not due to an external offensive odor that he smells but to his irrational fear that he is emitting a foul or unpleasant odor such as bad breath or foul overall body odor. The obsession of olfactory reference syndrome may be an exaggerated concern with a natural body smell, or may appear as an imagined odor. Though similar in some respects, our patient is not precisely an olfactory reference syndrome case. Another OCD related to smell that is similar to our case is bromidrophobia. It is a form of obsessional fear of body odors.

The patient was first referred to the Psychiatry Department of the University of Malaya Hospital. The medicine prescribed to him caused him headache and difficulty to urinate. The latter might have been a rare side effect of tricyclic drugs. He stopped the treatment and was feeling that his condition was becoming worse. He was then sent to Ampang Clinic in which the psychiatrist prescribed an antianxiety drug that greatly improved his condition, however his OCD continued unabated. His psychiatrist then referred him back to Dewan Bandar Kuala Lumpur Hospital for psychotherapy.

Discussion

Meyer developed EPT from observing that frightened animals got over their phobias when they were exposed for a long time to what scared them while preventing them from escaping [3]. Many patients avoid being treated by EPT because of the excessive anxiety encountered when strictly prevented from their compulsions. In discussing this issue, Professor Adam Radomsky stated that "Refusal rates for ERP are unacceptably high, which is why we need to develop a new refined treatment[4]."

Our treatment created much less anxiety because we followed a gradual approach and we neutralized the offensive smell with its opposite; the perfume. This is similar in some ways to reciprocal inhibition and our gradual exposure resembled systematic desensitization therapy of Wolpe [5]. Furthermore, the cognitive restructuring and our psychospiritual technique of mindfulness and acceptance were repeated after each sniff of the bad odor and the spraying of perfume. Combining these therapeutic strategies may be of great help to patients with similar psychopathology by benefiting from the combination of different therapeutic strategies and by reducing the excessive anxiety of EPT.

The treatment of choice to OCD is the behavioral therapeutic technique known as the

Exposure and Prevention therapy (EPT) in which the patient is exposed to the noxious stimulus that triggers his obsession while strictly preventing him or her from engaging in his or her compulsions [6]. This ingenious technique was first developed by Dr. Victor Meyer [7]. I wish to record here that I had the privilege of directly observing the treatment of Meyer's first OCD case that led to the birth of this novel treatment. This was in 1966 in the Department of Psychiatry of the Middlesex Hospital Medical School where I was then serving as a clinical assistant and a trainee of Dr. Meyer.

The first patient of Meyer was a man and not a woman as mentioned by Professor Jack Rachman [8]. He was a London pathologist who accidentally spilled germs of a dangerous disease on the seat of his car. He panicked and washed and rewashed the seat with all kinds of disinfectants. His trauma ended up as an incapacitating fear of infectious diseases and dirt, particularly sticky substances. He spent most of his day cleaning and washing his hands and any object that he touched before washing.
He was exposed to dirt and his hands smeared with sticky jam and prevented from engaging in his cleaning rituals since the water in his room was turned off. He became extremely anxious; almost panicky. Valium was prescribed for him to reduce this unbearable anxiety. In a few days his improvement was dramatic.

In closely applying EPT to our patient, we would have simply subjected him to bad smell and prevented him from showering or changing his dress. Though this was essentially the therapeutic strategy that we followed, we have introduced novel adaptations that rendered our therapy to be more of the classical reciprocal inhibition and systematic desensitization techniques than the straight forward exposure-prevention therapy. We have also combined our therapy with cognitive restructuring and some aspects of what is now known as the third wave of CBT. Third wave CBT which is still in the process of taking its final shape in the West, has always been used by Muslim therapists and traditional healers. I have been using mindfulness and acceptance within a spiritual therapeutic context since 1967 without realizing that a day will come when it becomes a "third wave" [9].

We started with cognitive restructuring. He was encouraged to realize that his compulsion of washing away a bad smell by showering and changing into clean clothes was irrational and childish rooted in his mother's exaggerated response to bad smell. CBT helped him to realize that his real problem was not specifically the bad smell. The problem was his attempt to get rid of his discomfort in an irrational manner. Our mindfulness and acceptance therapy helped him to accept his predicament as a Divine fate and a test for which he would be spiritually rewarded. The aim of this introductory phase of the treatment was to give him a cognitive rational foundation for the exposure-prevention therapy. The second phase was to apply the modified EPT. For this, the therapist came to the clinic with a rotten fish in a plastic bag together with a bottle of perfume that could be sprayed. As already mentioned, rotten fish was his most abhorrent bad smell. The patient was initially asked to smell the fish for a few seconds. As he did so and his anxiety mounted, the therapist closed the bag and sprayed the perfume near his face and asked him to relax his muscles and breathe abdominally and enjoy the comforting fragrance and to contemplate on the absurdity of his irrational thought and compulsions and to dwell on imaginal acceptance of bad smell. The irrationalness of feeling dirty and contaminated because of bad smell was exposed by showing the ridiculousness of being clean in body and attire just because of inhaling the nice smell of the perfume.

The whole process was repeated with gradually increasing the time of smelling the rotten fish. His progress was dramatic; observed from the very first therapeutic session. He was given the rotten fish and the perfume and asked to practice at home and to bring them to the clinic for further sessions. After 4 sessions the patient was able to tolerate sniffing the bad odor of the fish continuously for more than 5 minutes and to spray the perfume only for a few seconds without having the compulsive urge to shower. He resumed his job as a cleaner but kept a bottle of his preferred perfume in his bag to inhale its

refreshing fragrance if he encountered any offensive smell. He expressed his wish to terminate the therapy since he felt confident that he has improved. His improvement was sustained until I left my part-time job as a clinical psychologist in 2004.

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