THE PSYCHIATRIST'S TOOLBOX

The Challenge of Treating Facial Tics

Facial tics and tic-like movement that spreads to the shoulders, parts of the torso, or other parts of the body are difficult to treat. The patients I've treated with tic disorders had one thing in common: They knew that the tics worsened when they were under stress.

None had Tourette's syndrome. They all had tried medications that either were ineffective or had side effects that proved troubling. Because of these problems, the patients had stopped medicinal treatments.

We know that tics many times start in childhood. Sometimes they are transient, but they also can persist for a lifetime.

I'd like to discuss two instances in which I treated simple tics.

One man had been told that his tics started after an infection. There might have been something to that idea. In one theory of tic origin, for example, they might begin after a streptococcal infection.

Both of my patients had been told that the simple tics disappeared during sleep. That information suggested that a relaxation approach might work best.

One patient sought my assistance based on the recommendation of a colleague who I had successfully treated for smoking cessation using hypnosis as an adjunct. The patient with the tics, an attorney who worked as a litigator, had tried multiple medications. None had helped, and he found the side effects troubling.

He said that the facial tics had started around age 9 or 10 years after he had been sick with a bad sore throat. The pediatrician had assured the family that tics could happen after an infection and was optimistic that they would go away, but no treatment was sought until the patient himself, as an adult, sought it out.

The other patient had no idea why the tics had occurred, but said that they had been present since he was about 10 years old. He was a successful businessman who felt that the tics became worse when he was under stress, particularly when he was trying to close in on a project. Interestingly, the first patient also reported that the tic phenomenon got worse under stress.

I decided to use the same strategy for both patients involving relaxation and projection coupled with reciprocal inhibition. I taught a simple relaxation/hypnotic technique, therefore reducing anxiety and reducing tics.

BY ROBERT T. LONDON, M.D.

Each patient was taught to sit quietly in an easy chair, take three or four deep breaths, and allow himself to float into a relaxed state.

I suggested that the patient try to imagine that his facial and neck muscles were becoming more and more relaxed, focusing more and more on the muscle groups where the tics occurred.

At this point, I would have the patient come out of this relaxed state and then go back into it at least six to eight times during our first visit. The point was to help the patient know and understand the relaxation strategy without my help. I noticed that the tics disappeared as the patient relaxed these muscle groups.

The point of the repetition was for the patient to become as good as I am in inducing relaxation states and to empower him to gain control of the tic movement. In addition, I always teach a very quick method of reaching a relaxed state (5-10 seconds) in which the patient can enter this state when necessary to decrease or avoid the tic phenomenon.

For the second visit, I offered each patient two separate strategies: one in projection and the other as a behavioral/habit control technique.

In the projection technique, I had the patient see himself on a big movie screen experiencing the tics. As the visualization got projected on the screen, it left the patient. It's an interesting approach to project a physical experience onto a screen—not unlike what a patient would do when trying to deal with chronic pain patterns. They, of course, need the practice effect so it can be done very quickly when stress is coming on or has arrived.

The other strategy is one I have used successfully for nail biting. This approach is used when the patient is feeling under stress, as the businessman felt when he was at the close of a project. The attorney found that his stress tended to come during legal presentations.

The strategy is quite simple. When the patient senses that the tic is becoming overwhelming, he tries to soothe himself by touching the facial area or neck area and repeating to himself: "Relax, relax, relax." The patient also can give himself reassurances such as "You need not be nervous." In a matter of seconds, for these two patients, the tics became less prevalent.

It is interesting to see how self-awareness about a particular problem and a focus on addressing the problem can be therapeutic. In this strategy, the patient reinforces self-care and even self-love. And both patients took their assignments seriously.

There are many ways to help control simple tics. A dance/art therapist I know, Mara Rivera, told me that she has worked with people who have movement disorders, including simple tics. Ms. Rivera says it appears that the flow of movement leads to a reduction of simple tics, and she has seen the tics stop when people learn how to enter into this flow. She hypothesizes that such reductions can be lasting, because they become part of body memory.

An interesting and valuable bit of information comes from a recent study (Clin. Psychol. Sci. Prac. 2007;14:252-267). Researchers at the University of California, Riverside, found that habit reversal training (HRT) and exposure and response prevention (ERP) were two psychosocial treatments that meet evidence-based standards for the control of tic disorders. I believe that I was doing this work before HRT and ERP were deemed helpful. Still, it's great to see behavioral therapies making such fine advances.

Certainly, more psychiatrists and psychologists might want to explore the treatment of tic disorders by looking at my work, by exploring the observations of people doing dance therapy such as Ms. Rivera, or by using HRT and ERP methods.

Let me know your thoughts on psychosocial treatments for tic disorders, and I will try to pass them along to my readers. ■

DR. LONDON *is a psychiatrist with the New York University Medical Center and Lutheran Medical Center, New York. He can be reached at cpnews@elsevier.com.*

Citalopram Appears Effective for Reducing Hot Flashes

BY KERRI WACHTER
Senior Writer

CHICAGO — Citalopram may be an effective option for reducing hot flashes, having performed twice as well as placebo in a randomized, placebo-controlled phase III trial conducted by the North Central Cancer Treatment Group.

"Hot flash relief can be obtained with as little as 10 mg/day citalopram," Debra Barton, Ph.D., of the Mayo Clinic in Rochester, Minn., and her coauthors concluded in a poster reporting results of the trial at the annual meeting of the American Society of Clinical Oncology.

A selective serotonin reuptake inhibitor (SSRI), citalopram (Celexa) is approved for depression, but is also used for some other disorders.

Postmenopausal women who had a history of breast cancer or wanted to avoid hormones due to breast cancer risk were enrolled in the study. They had to have at least 14 hot flashes per week for at least 1 month. Endocrine therapy was allowed, if the woman was on a stable dose for at least 1 month. No other antidepressants or hot flash therapies were permitted.

All 254 participants kept a record of their hot flashes for 1 week before starting treatment, The investigators randomized the women into four groups that received either (group 1) 10 mg/day of citalopram on weeks 2-7, (group 2) 10 mg/day of citalopram during week 2 followed by 20 mg/day of citalopram for weeks 3-7, (group 3) 10 mg/day of citalopram during week 2 followed by 20 mg/day for week 3 and 30 mg/day for weeks 4-7, or (group 4) placebo.

Mean reductions in hot flash frequency were 46%-50% for citalopram and 20% for placebo.

DR. BARTON

The placebo group comprised 83 women; each citalopram arm had 57 women. Most participants were 50 years or older (81%) and white (89%). A third of the women (34%) had a history of breast cancer. Nearly half the women (48%) had 4-9 hot flashes per day, another 38% had 10 or more per day, and 13% had less than 4 per day (13%). Mean baseline hot flash score and frequency were comparable between the groups.

The primary outcome, hot flash score, was measured with a daily diary. Secondary outcomes included data from Hot Flash Daily Interference and Profile of Mood States measures and from a symptom experience diary.

Women in the placebo group had a mean hot flash score reduction of 23%. Women in the 10 mg, 20 mg, and 30 mg citalopram groups had mean reductions of 49%, 50%, and 55%, respectively, with the differences relative to placebo being statistically significant for all three citalopram groups.

The mean reduction in hot flash frequency was 20% for the placebo group. The mean reductions for the 10-mg, 20- mg, and 30-mg citalopram groups were 46%, 43%, and 50%, respectively. Again all three comparisons to placebo were statistically significant.

The researchers also looked at quality of life measures. On the Profile of Mood States measure, women in the citalopram arms had greater improvement from baseline than did those in the placebo group on the tension/anxiety subscale, though the difference was only significant for the 20-mg citalopram group. Likewise, women in the citalopram arms had greater improvements from baseline than did those in the placebo group on the anger/hostility subscale, though the difference was only significant for the 10-mg arm.

On the Hot Flash Daily Interference Scale, women in the citalopram arms generally had greater improvements from baseline than did those in the placebo group on measures of work, social, leisure, sleep, mood, concentration, relationships, sexuality, enjoyment of life, and overall quality of life.

Women on any dose of citalopram also had significantly greater improvements in abnormal sweating, hot flash distress, and hot flash control than did women in the placebo group.

The authors reported no conflicts of interest. ■

Pages 48a—48b◊