Original Research Paper Medical Science

Case history: Obsessive Compulsive Disorder

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KEYWORDS

History of Present illness:-
The patient was apparently well 1 ½ yrs. back. As per the informant, the patient got married at the age of 17 yrs. her husband was a heavy drinker. He was consuming alcohol excessively. In fact, her in-laws also took it regularly. Her husband and in-laws were very greedy, they always demanded for dowry. Sometimes, after drinking, her husband beat her and abused her. The patient got frustrated. Finally, to get rid of her frustration, she started to take alcohol excessively. She was consuming alcohol since 4 years. After sometime, the patient decided to give divorce to her husband. She gave divorce to her husband 8 yrs. back. The patient had two children. Elder one is the girl who is living with her father, and younger one is the boy who is living with the patient only. She used to live with her child in a rental house. Her expenditure was bored by her parents. After sometimes, she got attached with her neighbor. The patient made physical relation with that boy. She was enjoying with that boy. After sometime, her all expenditures were bored by her boyfriend. As per the patient, once her boyfriend told her to bring her friends with her for outing. All of a sudden, from that moment she started having fear of rejection by her boyfriend. She started thinking that she is not beautiful, that is why her boyfriend is not showing interest in her. To become more beautiful, she started bathing daily half an hour. She started brushing half an hour. She used to spend most of the time in washroom. In due course of time, prior leaving the house, she started the checking rituals. As per the patient, prior leaving the house, she thinks, is everything turned off and locked, and it will be my fault, if something bad happens. Her sleep was disturbed by frequent awakenings. After awakenings, she had problem in falling asleep. The patient was being treated by the psychiatrist in Bilaspur, since one year, but when she did not get relief, so she was taken to Raipur. No history suggestive of head injury, epilepsy, psychoactive substance use and Schneider's first rank symptoms in relation to symptomatology. No history suggestive of any psychiatric illness in family.

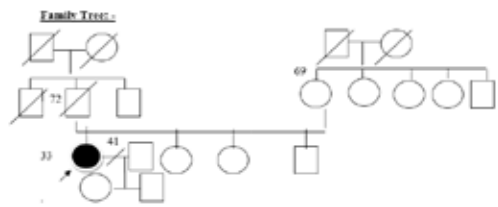
TREATMENT HISTORY: - The patient was being treated by the psychiatrist in Bilaspur, since one year, but when she did not get relief, so she was taken to Raipur.

HISTORY OF PAST ILLNESS: - There is no history suggestive of Psychiatric illness in the past. She had suffered from Malaria one month ago.

FAMILY HISTORY: -
Patient is the first order child among four siblings, born to non-consanguineous parents belongs to a nuclear family from low- socio economic status.

- Father passed away at the age of 72, Illiterate, by occupation he was a farmer and his attitude towards patient was good.
- Mother, 69 years old, working as a farmer, and her attitude toward patient was loving and caring.
- No history suggestive of any psychiatric illness in family among three generations.

Family Tree: -



PERSONAL HISTORY: - Patient was full term normal delivered baby at hospital and the presence of birth cry could not be found. Her developmental milestones could not be assessed and she is the first order child among her four siblings. Home situation in childhood and adolescence was congenial. Her attitude towards her parents and siblings was loving, caring and affectionate with no parental lack before 18 years

EDUCATIONAL HISTORY: - Patient has started going to school at the age of 3 year. She was an average student in her studies & she has educated up to Class IX. Her peer relations in school were good.

OCCUPATIONAL HISTORY: Not applicable
MARITAL HISTORY- Age of marriage- 17, spouse age of marriage- 25. Marriage with parental consent. Marriage and sexual adjustment was not good.

PATIENTS AND PRESENT FAMILY SET UP:
Patient's relationship with her family members was found to be strained due to her illness & tends to be abusive and violent towards them. Attitudes of family members towards patient's illness are found to be supportive with no long standing family squabbles.

HABIT: - She was consuming alcohol since 4 years.

MENSTRUAL HISTORY:
She reached menarche at her age of 13 years.

PREMORBID PERSONALITY:
Patients was premorbidily cheerful & maintained a good peer relationship with sibling and respectful towards parents. Her attitude towards work & religion was diligent and respectful. She had a good aspiration about her carrier & maintained good level of responsibility in her work. As a whole she had a well – balanced premorbid personality.

MENTAL STATUS EXAMINATION
GENERAL APPEARANCE & BEHAVIOUR: -
She was well kempt and tidy in appearance. She had maintained proper eye contact with the examiner and proper touch with the surroundings.

RAPPORT: - was established with difficulty.

ATTITUDE TOWARDS EXAMINER: - was found to be cooperative

MOTOR BEHAVIOUR: - was retarded.

SPEECH: Her speech was found to be abnormally soft with normal fluctuations in normal reaction time and normal speed.

Ease of Speech: She speaks when questioned and her speech was relevant, coherent, goal directed with normal productivity in relaxed manner.

Deviation: Nil

DISORDER OF VOLITION: - No disorder.

AFFECT: -
Subjectively she said her affect was "Mann chidchida rhta hai". Objectively her affect was found to be irritable. Overall her affect was irritable which was not appropriate according to situation.

THOUGHT: -

Stream*: Normal*

Thought possession was absent.

Thought content: Absent.

PERCEPTUAL DISTURBANCES: - Absent.

ATTENTION & CONCENTRATION: - It was difficult to arouse and sustain; She was not able to begin simple subtraction (40-3) fully correct and backward counting (20 to1).

MEMORY: - On clinical assessment her memory was found to be intact.

On clinical assessment, his Remote Memory, recent memory was intact and Immediate Memory were impaired

ORIENTATION: - orientation to place, day, month and year were impaired.

INTELLIGENCE: -
On clinical assessment, Her Intelligence was found to be **average level**.

ABSTRACT THINKING:
Her abstract thinking came to be conceptual level.

JUDGEMENT: -
Her **social** and **personal** judgment was found to be appropriate and test was Poor.

INSIGHT: - Her insight was found to be level V- Intellectual Insight.

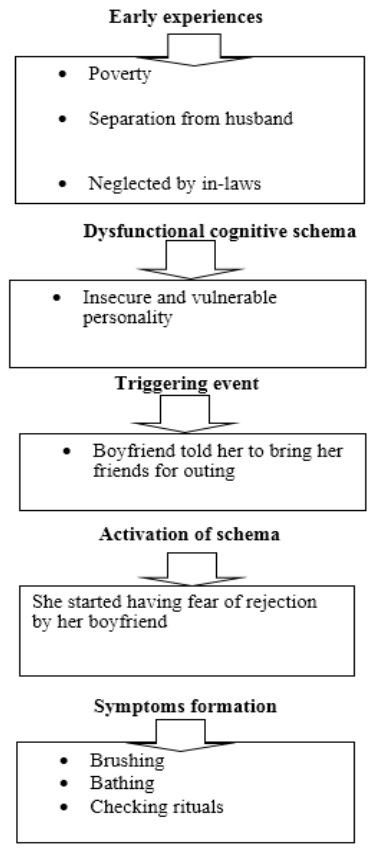
DIAGNOSTIC FORMULATION: the index patient, 33 yrs. old, female, educated up to 9th std., married, hails in urban area, belongs to middle SES, was brought by her mother with the chief complaints of takes too much time in washing, bathing and brushing, checking rituals, crying spells, disturbed sleep, disturbed appetite, which was precipitated by fear of rejection by her boyfriend, with insidious onset, continuous course, with deteriorating progress of illness, treatment history for present illness suggestive of she was being treated by the psychiatrist in Bilaspur, since one year, but when she did not get relief, so she was taken to Raipur, MSE suggested, well kempt and tidy in appearance, thought content suggestive of obsessive thought and compulsive act with insight at grade level V (intellectual insight).

Provisional Diagnosis : ICD 10 F42.2 Mixed obsessional thoughts and acts

Techniques and types of therapy with rationale

- **Psychoeducation:** to give information to parents about the nature of client's problem, its onset, progress and prognosis.
- **Supportive psychotherapy:** to give the patient for building up rapport and trust.
- **Activity scheduling:** this technique was given to enable the patient to manage time effectively.
- **Relaxation training:** Jacobson's Progressive Muscle Relaxation was used to reduce the arousal level in the client as she was very much anxious.
- **Exposure and response prevention:** to prevent the client's obsessive thoughts and compulsive acts.

PSYCHOTHERAPUTIC FORMULATION



GOALS OF THE THERAPY

Short Term goals

- To provide information about the illness to the parents and to the client
- To improve daily functioning of the patient
- To improve her social interaction with other
- To improve her sleep

Long Term goals

- To prevent relapse
- To control obsessive thoughts
- To prevent compulsive acts

Therapeutic procedure:
Session 1: In the initial phase of the therapy detail case history was taken.

Session 2:
Baseline assessment: In session 2, following test was used for baseline assessment.

Yale- Brown Obsessive Compulsive Scale: this scale was administered to assess the severity of the obsessive compulsive behavior of the patient. The total score of the patient on this

scale was 66, indicating extreme level of obsessive compulsive symptoms and it suggest patient spend excessive time in obsessive thoughts and acts and experience social and occupational interference due to the thoughts.

Session 3: In this session, parents were informed about the nature of client's problem, its onset, progress and prognosis. They also informed about the possible reasons behind her problem and a graphical representation of physiological responses during obsessional thoughts were discussed and the importance of therapy. Use and importance of therapy and drugs were also discussed along with its mode of actions, and its side effects. During this session 15 sessions were planned with duration of 45 minutes each with the patient.

Session 4: In this session, supportive therapy was given to the patient to build up rapport and trust. Therapist also provided motivational interviewing for therapy and reassurance to the patient. Patients were motivated to participate in therapy. They were regular to the sessions and were following the instructions given.

Session 5: All the activities of the patient were scheduled in such a manner that patient was able to manage her time effectively. Reinforcements were also used with her for doing work at the schedule timing.

Session 6: In this session, Jacobson Progressive Muscle Relaxation was given in the presence of her mother and asked to give the technique in the same manner at home. They were asked to do this daily at least twice a day.

Session 7: Initially, the rationale of the technique was explained to the family members. Once they were ready patient was asked situations which caused her anxiety and leads to her compulsive acts. Therapist then wrote them in a hierarchical order after asking her the least anxiety provoking situation to highest level of anxiety provoking situation. Graded imagery exposure was mainly utilized, the patient was deliberately exposed to imagine those situations or thoughts which caused her anxiety and then prevented to perform compulsive acts. Gradually, the patient was shifted to next anxiety provoking situation until the patient was able to control her anxiety. The patient was also given homework which she had to complete before next session, with the help of her family members and they were also taught the technique. This session was continued till 10^{th} sessions.

OUTCOME OF THE THERAPY:- Total 10 session were held, reassessment was done to see the improvement of the patient. A considerable change was found in obsessive compulsive behavior.

FUTURE PLAN: - Parents were instructed to continue medications regularly as per the psychiatrist's instruction along with maintenance of psychotherapy.