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Article

Obsessive Compulsive Disorder- A Case Study

[1]Mehak Abeerah

Graduate (Psychology), Amity University, Noida

* mehak.abeerah2001@gmail.com

Abstract

The present case study describes obsessional thoughts and compulsive behaviours, directed at "S," a 28-year-old Female suffering from obsessive compulsive disorder also exhibiting indications of psychosis**.** S refuses to acknowledge that anything is wrong, rejecting the idea of therapy or intervention. This denial is a significant barrier to her receiving help, as it prevents her from recognizing the need for treatment. The family has taken on the burden of explaining her actions, mood changes, and neglect of personal care to mental health professionals, in an attempt to advocate for her well-being. S's daughter helped S to sincerely practice the techniques instructed by the psychologist. S's family members were highly motivated to execute the treatment program effectively. The program consisted of intensive, multi-modal treatment Program. Therapeutic Interventions are: Acceptance and Commitment Therapy, Cognitive Behavioural Therapy, Exposure and Response Prevention, Cognitive Restructuring. ACT focuses on accepting thoughts and feelings rather than fighting them. It encourages mindfulness and commitment to personal values, which could help Ms. S. engage more meaningfully in her life. Cognitive Behavioural Therapy, specifically designed for OCD, it involves exposure and response prevention (ERP), where Ms. S. would gradually confront her fears and learn to refrain from engaging in compulsive behaviours. Cognitive Restructuring helps in addressing and modifying the distorted thinking patterns that contribute to her OCD and potentially her psychotic symptoms.

Keywords: OCD, Case Study, ACT

Introduction

A mental health illness known as obsessive-compulsive disorder (OCD) causes recurrent thoughts, or obsessions, which can subsequently result in repetitive behaviour, or compulsions. OCD is thought to affect 2.3% of American adults at some point in their lives, with women more likely than men to suffer from it (Mathes et al, 2019). Obsessions and obsessive-compulsive disorder (OCD) are characterized by unwanted, distressing, and uncontrollable thoughts. These intrusive thoughts might have a wide range of subjects and content, but they are frequently unsettling.

OCD is divided into two groups under which many sub-groups of symptoms are listed: a) Obsessions (*Thoughts, pictures, or concepts that are persistent, unwanted, and exceedingly upsetting or concerning are called obsessions. Obsessions frequently manifest as the following symptoms:) i.* Distressing violent thoughts or images ii. A need to have everything in a certain order iii. Fear of germs iv. Unwanted thoughts of forbidden or taboo topics such as sex or religion. b) Compulsions (*Behaviour that must be repeated repeatedly in order to alleviate anxiety are known as compulsions. Obsessions are frequently linked to compulsions. For instance, you may feel pressured to wash your hands frequently if you have an obsession with being contaminated. Typical compulsions include the following:) i.* Counting things over and over again ii. Excessive washing or cleaning iii. Ordering things in a particular or symmetrical way iv. Repeated checking (such as checking that the door is locked or that the oven is off)

Intrusive Thoughts that invade your head against your will are considered intrusive. They can be extremely frightening and terrible, and the person experiencing them typically feels as though they have no control over what is happening (APA). “Unwanted, involuntary thoughts, images, or ideas that can be disturbing to the individual experiencing them" is how Rachel Goldberg, LMFT, founder of Rachel Goldberg Therapy in Studio City, CA, defines intrusive thoughts. According to her, these ideas "frequently come to mind suddenly and can be persistent, which can cause significant anxiety (Seif et al)." In this case, Ms. S. experience intrusive thoughts that relate to her compulsions, such as fears of something terrible happening if she doesn’t check locks or appliances repeatedly. Her reported preoccupation with unimportant thoughts also reflects intrusive thoughts that disrupt her daily functioning and distract her from more meaningful activities or responsibilities. As she exhibits signs of psychosis, these intrusive thoughts may take on more bizarre or delusional qualities, contributing to her forgetfulness or altered perception of reality.

Impulsive Thought is like having an **itchy feeling** that you need to do something right away. “Impulsive thoughts are sudden urges or desires to act without considering the consequences,” Goldberg says. Impulsive thoughts can exist on their own, but they often lead to unwanted behaviours, such as making spontaneous purchases or acting aggressively toward others, Goldberg notes (Bakshani, 2014). Certain conditions are associated with impulsive thoughts, Goldberg notes, including attention deficit disorder (ADHD), bipolar disorder, and panic disorder (Herman, 2018). In this case, Ms. S.'s compulsions (e.g., repeatedly checking things) could be driven by impulsive thoughts, where the urge to perform a behaviour arises quickly, often in response to anxiety from her intrusive thoughts. As her mental state declines, she might

also experience impulsive thoughts related to avoidance, where the sudden urge to disengage from activities (due to disinterest or overwhelming feelings) could lead her to neglect personal care or responsibilities.

The exact causes of OCD are not known, but there are a few factors that are believed to play a role: i. Biological factors (Abnormal neural circuits in the brain are associated with OCD. If you have OCD, certain parts of your brain may have difficulty inhibiting and "turning off" obsessive thoughts and impulses to turn off (Pietrabissa et al, 2016). As a result, you may experience obsessions and/or compulsions. The breakdown of this system may be related to serotonin and other neurotransmitter abnormalities.) ii. Family history (You may also be at greater risk if there is a family history of the disorder. Research has shown that if you, a parent, or a sibling have OCD, there is about a 25% chance that another first-degree family member will also have it.) iii. Genetics (Although a single "OCD gene" has not been identified, OCD may be related to particular groups of genes.) iv. Stress (Stress of all types including unemployment, relationship difficulties, problems at school, illness, or childbirth can be triggers for symptoms of OCD.)

Three main theories of Obsessive-Compulsive Disorder: i. Biological Theories whereas, Biological causes of OCD study the circuit relay system between the orbitofrontal cortex, which is responsible for complex behaviours such as emotion regulation, evaluation, reward-based decision-making, and other goal-directed behaviour, to the thalamus. In this case, Ms. S.'s worsening symptoms could indicate a shift in her neurobiology, potentially exacerbated by stressors or other mental health issues. Obsessions and compulsions associated with OCD are frequently linked to sexuality, violence, and contamination, all of which are controlled by these specific circuits (Thorsen, 2018) ii. Cognitive-Behavioural Theories, almost everyone experiences bizarre or unexpected thoughts throughout the day. According to cognitive-behavioural theories of OCD, if you are vulnerable to OCD, you are unable to ignore these thoughts. In this case, Ms. S.'s compulsive checking behaviours (e.g., rechecking locked doors) can be understood as attempts to mitigate anxiety stemming from intrusive thoughts iii. Psychodynamic Theories of OCD state that obsessions and compulsions are signs of unconscious conflict that you might be trying to suppress, resolve, or cope with. These conflicts arise when an unconscious wish (usually related to a sexual or aggressive urge) is at odds with socially acceptable behaviour. Some psychodynamic treatments imply that making a person aware of their unconscious conflicts helps improve their symptoms; nevertheless, additional research is needed (Leichsenring, 2016). This theory suggests that Ms. S.'s compulsive behaviour stem from unresolved internal conflicts or anxiety that manifest as OCD symptoms. The denial of her symptoms might be viewed as a defense mechanism to protect her from distressing feelings or thoughts.

Psychosis is a loss of contact with reality, typically including delusions (false ideas about what is taking place or who you are) and hallucinations (seeing or hearing things that aren't there). It impacts the way that the brain processes information (Hanna et al, 2005). When experiencing psychosis, people may hear, see, feel, or believe things that are not real. Symptoms of psychosis include: i. Delusions ii. Disorganized, scattered thinking and speech

iii. Hallucinations iv. Thoughts that jump around from subject to subject. The exact causes of psychosis are not entirely clear and each person's experience may be different (Hudak).

Some forms of psychosis are brought on by a specific condition, such as: a) Bipolar disorder, which may involve manic episodes that can lead to psychosis b) Brief psychotic disorder, which is a short and sudden onset of psychosis, often in response to a stressful situation, that usually lasts less than a month c) Delusional disorder, which is marked by an inability to distinguish between what is real and imagined d) Drug-induced psychosis, which may occur when a person is withdrawing from a drug such as alcohol or methamphetamine e) Postpartum psychosis, a severe form of postpartum depression that, while relatively rare, requires emergency medical intervention f) Schizoaffective disorder, which involves symptoms of a mood disorder and schizophrenia g) Schizophrenia, which is characterized by a range of psychotic symptoms h) Schizophreniform disorder, a short-term type of schizophrenia i) Severe depression can also cause people to experience symptoms of psychosis (Hudak).

In Ms. S.'s case, the symptoms of psychosis are: i. A significant decline in self-care and neglect of personal hygiene, indicating a loss of motivation and interest in activities that were once important ii. Ms. S. has previously struggled with feelings of isolation, which may have intensified, contributing to a further disconnection from social interactions iii. A marked lack of interest or pleasure in activities she once enjoyed, which can be inferred from her signs of boredom and disengagement from daily activities iv. Ms. S. does not acknowledge her symptoms, it may suggest some degree of denial or distorted thinking.

Methodology

Case study methodology offers a valuable approach to research when in-depth understanding of a complex issue or phenomenon is desired. Unlike quantitative methods that prioritize breadth and generalizability, case studies delve deep into a specific instance, providing rich, contextualized insights. This method often involves multiple data sources, such as interviews, observations, and document analysis, to create a holistic picture. By meticulously examining a particular case, researchers can uncover nuanced details, identify patterns, and develop hypotheses that can inform further investigation or contribute to existing theories. Case studies are particularly useful in situations where experiments are not feasible or ethical, and they often provide compelling narratives that resonate with audiences.

Discussion

Case History

Ms. S., a long-term sufferer of Obsessive - Compulsive Disorder (OCD), has recently exhibited signs of worsening mental health, particularly with indications of psychosis. For the past five to six months, her behaviour and mood have shown noticeable changes, including signs such as boredom, preoccupation with trivial or unimportant thoughts, unexplained weight gain, and a general forgetfulness about people and things that were once familiar or important to her. This shift in her mental state has been gradual, but it is concerning because it represents a stark deviation from her previous condition.

Two years ago, Ms. S. was officially diagnosed with OCD, a disorder that had caused significant distress and disruption in her daily life. Her symptoms at the time included a range of obsessive and compulsive behaviours that defined her diagnosis. She struggled with feeling isolated from others, plagued by depressive thoughts, and frequently displayed irritability and aggression. Her anxiety became heightened whenever objects in her environment were not perfectly aligned, leading to considerable stress. Additionally, she felt compelled to check and recheck things constantly, such as whether doors were locked or appliances were turned off, reinforcing the compulsive aspect of her disorder.

However, more recently, Ms. S. has begun to exhibit negative symptoms associated with psychosis, a worrying development that goes beyond her initial OCD diagnosis. These negative symptoms include difficulties with concentration, a marked disinterest in personal grooming and hygiene, and an overall decline in her ability to engage with daily activities. These behaviours are especially concerning as they suggest a deeper cognitive decline, which is often characteristic of psychotic disorders, rather than just anxiety-driven behaviours associated with OCD.

Her family members have been the primary reporters of these symptoms, as Ms. S. herself has denied experiencing any of them. She refuses to acknowledge that anything is wrong, rejecting the idea of therapy or intervention. This denial is a significant barrier to her receiving help, as it prevents her from recognizing the need for treatment. The family has taken on the burden of explaining her actions, mood changes, and neglect of personal care to mental health professionals, in an attempt to advocate for her well-being.

The combination of her OCD-related behaviours and the new, negative symptoms of psychosis presents a complex clinical picture. Ms. S.'s refusal to engage in therapy complicates her path to recovery, as she may need more intensive interventions than before. Without intervention, her condition could worsen, possibly leading to more severe psychotic episodes or a further decline in her ability to function day-to-day.

Course of Treatment

The program consisted of intensive, multi-modal treatment Program.

Therapeutic Interventions are:

i) Acceptance and Commitment Therapy

ii) Cognitive Behavioural Therapy

iii) Exposure and Response Prevention

iv) Cognitive Restructuring

Along with these, therapeutic interventions, Ms. S and her family were psycho-educated about OCD and psychosis which can help normalize her experiences and reduce stigma. Understanding symptoms can also facilitate better communication and encourage her to seek help. Engaging family members in therapy can help improve communication, decrease familial

stress, and provide strategies to support Ms. S. effectively. Family dynamics can be addressed, and family members can learn how to advocate for her without enabling denial.

Developing a crisis plan that outlines steps to take if Ms. S.'s symptoms worsen. This could include emergency contact information and a list of supportive individuals who can intervene if necessary. Involvement in community support groups for individuals with OCD or mental health issues can help reduce isolation and provide social support. Establishing a daily routine that includes regular meals, exercise, and sleep can help stabilize mood and provide a sense of normalcy. Gradually encouraging Ms. S. to engage in self-care activities. This might start with small, manageable tasks to rebuild her motivation and sense of control. In addition, S could take necessary support from her therapist as and when required.

Conclusion

S, an OCD patient was presented to an Intensive Treatment Program. The success of this intervention depended on several factors. Most importantly, S's family was exceptionally dedicated towards the implementation of the instructions. S's daughter gave both physical and psychological support to her. Secondly, the intervention package was tailored according to S's OCD symptoms. Cognitive Restructuring helps in addressing and modifying the distorted thinking patterns that contribute to her OCD and potentially her psychotic symptoms.

Despite the challenges posed by OCD, effective treatment options, including Cognitive Behavioral Therapy (CBT) and pharmacological interventions, offer hope for many. However, ongoing research is crucial to better understand the neurobiological underpinnings of the disorder and to develop innovative therapeutic strategies.

Moreover, increasing awareness and reducing stigma surrounding OCD are essential steps in fostering a supportive environment for those affected. By prioritizing research and education, society can improve the quality of life for individuals with OCD and help them navigate the challenges posed by this condition. Ultimately, a comprehensive approach that combines clinical expertise, community support, and individual resilience is key to addressing the complexities of OCD

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