

# A case study of obsessive impulsive disorder

Education



## A Case Study of Obsessive-Compulsive Disorder:

**Some Diagnostic Considerations** INTRODUCTION Prior to 1984, obsessive-compulsive disorder (OCD) was considered a rare disorder and one difficult to treat (1). In 1984 the Epidemiologic Catchment Area (ECA) initial survey results became available for the first time, and OCD prevalence figures showed that 2.5% of the population met diagnostic criteria for OCD (2, 3). Final survey results published in 1988 (4) confirmed these earlier reports. In addition, a 6-month point prevalence of 1.6% was observed, and a life time prevalence of 3.0% was found.

OCD is an illness of secrecy, and frequently the patients present to physicians in specialties other than psychiatry. An other factor contributing to under diagnosis of this disorder is that psychiatrists may fail to ask screening questions that would identify OCD. The following case study is an example of a patient with moderately severe OCD who presented to a resident psychiatry clinic ten years prior to being diagnosed with OCD. The patient was compliant with out patient treatment for the entire time period and was treated for major depressive disorder and borderline personality disorder with medication and supportive psychotherapy.

The patient never discussed her OCD symptoms with her doctors but in retrospect had offered many clues that might have allowed a swifter diagnosis and treatment. **CASE HISTORY** Simran Ahuja was a 29 year old, divorced, Indian female who worked as a file clerk. She was followed as an out patient at the same resident clinic since 1971. I first saw her 2012. **PAST PSYCHIATRIC HISTORY** Simran had been seen in

the resident out patient clinic since July of 1984. Prior to this she had not been in psychiatric treatment. She had never been hospitalized .

Her initial complaints were depression and anxiety and she had been placed on an phenelzine and responded well. Her depression was initially thought to be secondary to amphetamine withdrawal, since she had been using diet pills for 10 years. She stated that at first she took them to lose weight, but continued for so long because people at work had noted that she concentrated better and that her job performance had improved. In addition, her past doctors had all commented on her inability to change and her neediness, insecurity, low self-esteem, and poor boundaries. In addition, her past doctors had noted her promiscuity.

All noted her poor attention span and limited capacity for insight. Neurological testing during her initial evaluation had shown the possibility of non-dominant parietal lobe deficits. Testing was repeated in 1989 and showed "problems in attention, recent visual and verbal memory (with a greater deficit in visual memory), abstract thought, cognitive flexibility, use of mathematical operations, and visual analysis. A possibility of right temporal dysfunction is suggested." IQ testing showed a combined score of 77 on the Adult Weschler IQ test, which indicated borderline mental retardation.

Over the years the patient had been maintained on various antidepressants and anti-anxiety agents. These included phenelzine, trazadone, desipramine, alprazolam, clonazepam, and hydroxyzine. Currently she was on fluoxetine 20 mg daily and clonazepam 0.5 mg twice a day and 1.0 mg at bedtime. The

antidepressants had been effective over the years in treating her depression. She has never used more clonazepam than prescribed and there was no history of abuse of alcohol or street drugs. Also, there was no history of discreet manic episodes and she was never treated with neuroleptics.

**PAST MEDICAL HISTORY** She suffered from gastroesophageal reflux and was maintained symptom free on a combination of ranitidine and omeprazole.

**PSYCHOSOCIAL HISTORY** Simran was born and raised in a large city. She had a brother who was 3 years younger. She described her father as morose, withdrawn, and recalled that he has said, "I don't like my children. Her father was physically and verbally abusive throughout her childhood. She had always longed for a good relationship with him. She described her mother as the family martyr and the glue that held the family together.

She stated that she was very close to her mother; her mother always listened to her and was always available to talk with her. She was a poor student, had difficulty all through school, and described herself as "always disrupting the class by talking or running around." She had a best friend through grade school whom she stated "deserted" her in high school. She had maintained few close friends since then. She graduated high school with much difficulty and effort. She dated on group dates but never alone. Her husband left her while she was pregnant with her son.

The husband was a bus driver and had not had a role in their lives since the divorce. After the divorce, she moved back to her parents' home with her son and remained there until getting her own apartment 3 years ago.

**FAMILY HISTORY** Simran's mother had two serious suicide attempts at age 72 and was diagnosed with major depressive disorder with psychotic

features and OCD. She also had non-insulin dependent diabetes mellitus and irritable bowel syndrome. Her brother was treated for OCD as an outpatient for the past 20 years and also has Hodgkin's Disease, currently in remission.

The brother's diagnosis of OCD was kept secret from her and did not become available to her until her mother died. Her father is alive and well.

**MENTAL STATUS EXAM** She was a thin, bleached blond woman who appeared her stated age. She was dressed in skin tight, provocative clothing, costume jewelry earrings that eclipsed her ears and hung to her shoulders, heavy make-up and elaborately styled hair. She had difficulty sitting still and fidgeted constantly in her chair. Her body language throughout the interview was sexually provocative. Her speech was rapid, mildly pressured, and she rarely finished a sentence.

She described her mood as "anxious." Her affect appeared anxious. Her thought processes showed mild circumstantiality and tangentiality. More significant was her inability to finish a thought as exhibited by her incomplete sentences. **COURSE OF TREATMENT** Initial sessions with the patient were spent gathering history and forming a working alliance. Although she showed a good response by slowing down enough to finish sentences and focus on conversations, she could not tolerate the side effects and refused to continue taking the medication. The winter of 1993-94 was particularly harsh.

The patient missed many sessions because of bad weather. A pattern began to emerge of a consistent increase in the number of phone calls that she made to the office voice mail to cancel a session.

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When she was questioned about her phone messages she stated, " I always repeat calls to make sure my message is received. " Since the most recent cancellation generated no less than six phone calls , she was asked why a second call wouldn't be enough " to be sure . " She laughed nervously and said, " I always repeat things. " With careful questioning the following behaviors were uncovered.

The patient checked all locks and windows repeatedly before retiring. She checked the iron a dozen times before leaving the house . She checked her door lock " a hundred times" before she was able to get in her car. The patient washed her hands frequently. She carried disposable washcloths in her purse " so I can wash as often as I need too . " She said people at work laugh at her for washing so much. But she stated , " I can' t help it. I've been this way since I was a little girl. " When questioned about telling former doctors about this, the patient stated that she had never talked about it with her doctors.

She stated that everyone that knew her simply knew that this was the way she was: " It's just me . " In fact , she stated, " I didn't think my doctors would care... . I've always been this way so it 's not something you can change . " Over the next few sessions, it became clear that her arguments with her boyfriend centered on his annoyance with her need to constantly repeat things. This was what she always referred to as " talking too much . " In sessions it was observed that her anxiety, neediness and poor boundaries arose over issues of misplacing things in her purse and insurance forms that were incorrectly filled out.

In fact, when I attempted to correct the insurance forms for her, I had difficulty because of her need to repeat the instructions to me over and over. The Introduction Obsessive compulsive disorder (OCD) is an anxiety disorder characterised by persistent obsessional thoughts and/or compulsive acts. Obsessions are recurrent ideas, images or impulses, which enter the individual's mind in a stereotyped manner and against his will. Often such thoughts are absurd, obscene or violent in nature, or else senseless. Though the patient recognises them as his own, he feels powerless over them.

Similarly, compulsive acts or rituals are stereotyped behaviours, performed repetitively without the completion of any inherently useful task. The commonest obsession involved is fear of contamination by dirt, germs or grease, leading to compulsive cleaning rituals. Other themes of obsessions include aggression, orderliness, illness, sex, symmetry and religion. Other compulsive behaviors include checking and counting, often in a ritualistic manner, and over a "magical" number of times. About 70% of OCD patients suffer from both obsessions and compulsions; obsessions alone occur in 25%, whilst compulsions alone are rare. In she spent ten minutes checking and rechecking the form against the receipts. She became convinced that she'd done it wrong, her anxiety would increase, and she would get the forms out and check them again. Her need to include me in this checking was so great that she was almost physically on top of my chair. In the following weeks, sessions focused on educating the patient about OCD. Her dose of fluoxetine was increased to 40 mg a day but discontinued because of severe restlessness and insomnia.

She continued to take 20 mg of fluoxetine a day. Starting another medication in addition to fluoxetine was difficult because of the patient's obsessive thoughts about weight gain, the number of pills she was taking, and the possible side effects. Finally, the patient agreed to try adding clomipramine to her medications. The results were dramatic. She felt "more relaxed" and had less anxiety. She began to talk, for the first time, about her abusive father. She said, "His behavior was always supposed to be the family secret. I felt so afraid and anxious I didn't dare tell anyone.

But now I feel better. I don't care who knows. It's cost my mother too much to stay silent." At this time the plan is to begin behavioral therapy with the patient in addition to medications and supportive therapy to deal with her difficulties with relationships.

**DISCUSSION** This is a complicated case with multiple diagnoses: borderline mental retardation, attention deficit disorder, borderline personality disorder, a history of major depressive disorder and obsessive compulsive disorder. Given the level of complexity of this case and the patient's own silence about her symptoms, it is not surprising that this patient's OCD remained undiagnosed for so long. However, in reviewing the literature and the case, it is instructive to look at the evidence that might have led to an earlier diagnosis. First of all, there was the finding of soft neurological deficits. The patient's Neuropsychological testing suggested problems with visuospatial functioning and visual memory, as well as attentional difficulties and a low IQ. In the past, her doctors were so



impressed with her history of cognitive difficulties that neuropsychological testing was ordered on two separate occasions.

Four studies in the recent literature have shown consistent findings of right hemispheric dysfunction, specifically difficulties in visuospatial tasks, associated with OCD (6, 7, 8, 9). The patient also had a history of chronic dieting, and although extremely thin, she continued to be obsessed with not gaining a single pound. This was a patient who took diet pills for 10 years and whose earliest memories involved her father's disapproval of her body habitus. Eating disorders are reviewed by some clinicians as a form of OCD. OCD.

Swedo and Rapoport (11) also note an increased incidence of eating disorders in children and adolescents with OCD. While this was no doubt true, the underlying obsessional content pointed directly to OCD and should have generated a list of screening questions for OCD. This underscores the need to be vigilant for diagnostic clues and to perform one's own diagnostic assessment when assuming the treatment of any patient. While the literature makes it clear that OCD runs in families, the patient was unaware of the illness in her family until after her diagnosis was made.

It would have been helpful to know this information from the beginning as it should immediately raise a suspicion of OCD in a patient presenting with complaints of depression and anxiety. Finally, her diagnosis of borderline personality disorder made it easier to pass off her observable behavior in the office as further evidence of her character structure. The diagnosis of borderline personality disorder was clear.

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She used the defense of splitting as evidenced by her descriptions of her fights with her boyfriend. He was either "wonderful" or a "complete bastard." Her relationships were chaotic and unstable.

She had no close friends outside of her family. She exhibited affective instability, marked disturbance of body image and impulsive behaviors. However, it was difficult to discern whether her symptoms were truly characterological or due instead to her underlying OCD and related anxiety. For instance, the instability in her relationships was, in part, the result of her OCD, since once she began to obsess on something, she repeated herself so much that she frequently drove others into a rage. A study by Ricciardi, investigated DSM-III-R Axis II diagnoses following treatment for OCD.

Over half of the patients in the study no longer met DSM-III-R criteria for personality disorders after behavioral and / or pharmacological treatment of their OCD. The authors conclude that this raises questions about the validity of an Axis II diagnosis in the face of OCD. One might also begin to wonder how many patients with personality disorders have undiagnosed OCD? Rasmussen and Eisen found a very high comorbidity of other Axis I diagnoses in patients with OCD. Thirty-one percent of patients studied were also diagnosed with major depression, and anxiety disorders accounted for twenty-four percent.

Other coexisting disorders included eating disorders, alcohol abuse and dependence, and Tourette's syndrome. Baer, investigated the comorbidity of Axis II disorders in patients with OCD and found that 52 percent met the <https://assignbuster.com/a-case-study-of-obsessive-impulsive-disorder/>

criteria for at least one personality disorder with mixed, dependent and histrionic being the most common disorders diagnosed. Given the frequency of comorbidity in patients with OCD, it would be wise to include screening questions in every psychiatric evaluation. These need not be elaborate. Questions about checking, washing, and intrusive, unwanted thoughts can be simple and direct. In eliciting a family history, specific questions about family members who check repeatedly or wash frequently should be included. Simply asking if any family member has OCD may not elicit the information, since family members may also be undiagnosed. In summary, this case represents a complicated diagnostic puzzle. Her past physicians did not have the information we do today to unravel the tangled skeins of symptoms. It is important to be alert for the possibility that this patient's story is not an uncommon one.

BIBLIOGRAPHY \*Psychologybook (NCERT) \* Identical \* Suicidal notes \* A psychopath test: journey through the world of madness \* Disorder of impulse control by Hucker INDEX \* Introduction \* Case study \* Course of treatment \* Discussion \* Bibliography ACKNOWLEDGEMENT I would like to express my special thanks and gratitude to my teacher Mrs. Girija Singh who gave me the golden opportunity to do this wonderful project on the topic 'obsessive-compulsive disorder', which also helped me in doing a lot of research and I came to know about so many new things.

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titled ' obsessive-compulsive disorder' under the guidance of Mrs. Girija Singh. Also this project project is as per cbse guidelines 2012-2013. Teacher's signature (Mrs. Girija Singh) (Head of psychology department) 2012-2013 PSYCHOLOGY PROJECT NAME OF THE CANDIDATE: JAILAXMI RATHORE CLASS: XII ARTS B SCHOOL: MGD GIRLS' SCHOOL