



LIVING WITH OCD: A CLINICAL CASE STUDY OF OBSESSIVE-COMPULSIVE DISORDER

¹Aditya Singh Manav

**BA+MA Clinical Psychology, Amity Institute of Psychology and Allied Sciences, Noida, Uttar Pradesh, India*

092000adityarajput@gmail.com

²Dr. Kaushalendra Mani Tripathi

*** Associate Professor, Amity Institute of Psychology and Allied Sciences, Noida, Uttar Pradesh, India*

kmtripathi@amity.edu

Abstract

This case study focuses on a 52-year-old Delhi patient who has had obsessive-compulsive disorder (OCD) for eight years. The patient, a middle-class housewife who was brought in by her husband, exhibits signs of recurrent anxiety, obsessive hand washing, and a recurrent fear of contamination, which causes her to wash her hands ten to fifteen times a day. Her everyday functioning is greatly impacted by the symptoms, which started subtly and have persisted, leading to annoyance and anger. The main complaints are increased self-discipline, aggressive conduct, and persistent, recurring concerns of contamination. These symptoms continue even after attempts to find relief via yoga. This instance demonstrates how OCD interferes with day-to-day functioning and interpersonal connections, underscoring the significance of family support and treatment therapies. To improve her coping skills and quality of life, individualized treatment plans and ongoing monitoring are advised.

Keywords: *Obsessive compulsive disorder, Obsessions, Compulsions*

Introduction

Recurring, unwanted thoughts (called obsessions) and repeated activities (called compulsions) that a person feels compelled to carry out are hallmarks of obsessive-compulsive disorder (OCD), a chronic mental health illness (American Psychiatric Association, 2013). Obsessions that frequently result in compulsive behaviours like frequent cleaning, inspecting, or arranging include doubts, worries of contamination, and an overwhelming need for order. Although frequently illogical, these actions offer momentary solace from worry but can seriously harm day-to-day functioning and quality of life (Stein et al., 2019). OCD affects people of various ages, genders, and cultural backgrounds, with a frequency of 1% to 2% in the general population (Ruscio et al., 2010). According to Abramowitz et al. (2009), OCD frequently starts in childhood or early adulthood and, if untreated, tends to have a chronic, erratic course. Notably, the level and nature of symptoms can differ greatly from person to person; some people have minor, controllable symptoms, while others have severe, incapacitating compulsions that interfere with day-to-day functioning. Co-occurring diseases including depression, anxiety disorders, and drug use disorders are frequent among OCD sufferers and can make treatment more difficult, which further exacerbates the disorder's impact (Torres et al., 2011).

Causes of OCD

The exact etiology of OCD is still unknown, recent research indicates that a mix of environmental, neurological, and genetic variables may play a role in its development (Stein et al., 2019). According to twin and family studies, OCD has a genetic component, and close relatives of people who have the condition are more likely to get OCD themselves (Pauls et al., 2014). OCD may be linked to anomalies in serotonin function, since genes that affect the serotonin system—which is essential for mood regulation—have been identified (Goodman et al., 2014).

From a neurological viewpoint, studies have shown that people with OCD have abnormalities in areas of the brain such as the orbitofrontal cortex, anterior cingulate cortex, and basal ganglia. Since these brain areas are important in making decisions, controlling emotions, and forming habits, OCD may result from dysregulation in the circuits that govern how people react to rewards and fears (Milad & Rauch, 2012). According to research using functional magnetic resonance imaging (fMRI), people with OCD frequently exhibit

hyperactivity in these regions, which is correlated with how severe their symptoms are (Stein et al., 2019).

Stress and trauma are two examples of environmental variables that can significantly contribute to the onset or worsening of OCD symptoms. In susceptible people, life events like sickness, abuse, or a major loss may trigger the formation of OCD or exacerbate pre-existing symptoms. An increased risk of OCD and other anxiety-related disorders is associated with early exposure to stressful or traumatic situations, especially during formative years (Mathews et al., 2008).

Research Methodology

Data was gathered using a variety of techniques, including:

Clinical Interview: The patient underwent a systematic interview that included personal, family, and medical history in addition to the history of presenting symptoms, symptom onset, and course. To provide a precise evaluation of OCD symptoms, the interview adhered to the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) (American Psychiatric Association, 2013) recommendations.

Informant Interview: To confirm and contextualize the patient's self-reported symptoms, the husband was questioned to get supplementary information. His observations helped to clarify the patient's obsessive habits and behavioural patterns, and how they affected her quality of life.

Behavioural Observation: To evaluate obsessive behaviours like avoidance and hand washing, the patient was watched throughout clinical sessions. This made it possible to see the frequency and intensity of symptoms directly, giving objective data to support self-reported information.

Document Review: To look for prior mental diagnoses, medical disorders, and treatment histories, past medical records—if any were available—were examined. Her longstanding OCD symptoms without concurrent mental problems were confirmed by the absence of any noteworthy psychiatric background.

Case study

Demographic details

Name: Mrs. S

Age: 52 years

Sex: Female

Marital status: Married

Occupation: Housewife

Residence: Delhi

Religion: Hindu

Socioeconomic status: Middle class

Informant: Husband

Informants

Relationship: Husband

Husband & patient

- Aggressive
- Restlessness/ irritate
- Anxious
- Repetitive thought
- Extremely self-disciplined
- Look at the concentration
- Washing hands and cleaning repetitively

Onset: The patient reported having an insidious onset.

Course: Continuous

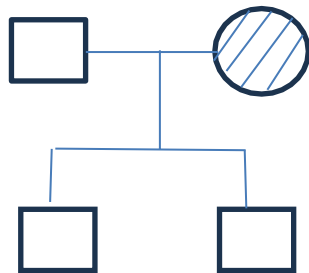
Duration: 8 year

History of present illness: The symptoms of OCD presented themselves for 8 years. The patient has visited the OPD with his husband. She complains that fear in her mind, “if I touch any item in the house, then I feel like a virus has come onto my hands and this problem occurs 10 to 15 times a day. I wash my hands 10 to 15 times a day. I feel amazed doing yoga and I feel very irritated.”

Past psychiatric history and medical history: No past psychiatric history.

Family history: No significant family history

Genogram:



Personal History:

Perinatal history	}	all millstones achieved on time
Developmental history		
Childhood history		

Mental Status Examination (MSE)

The following is the finding of the mental status examination of the client done during the intake session.

1. General behavior

- She was well dressed.
- She was not cooperative and help-seeking.
- She did not maintain eye-to-eye contact.

2. *Psychomotor activity*

- Abnormality of psychomotor activity

3. *Speech*

- Rate – Average
- Volume - maintained
- Reaction - average
- Tone - maintained

4. **Mood** : Her mood was happy and cheerful (“khush hu”),

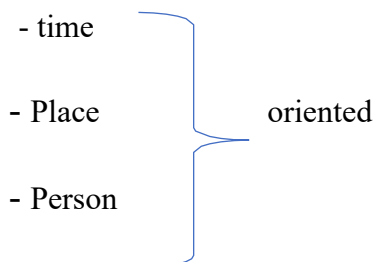
5. **Affect** : Her effect presently appeared to be restless may be due to being in a hospital setting, though appeared to be cheerful.

6. **Attention and concentration** – Sustained

7. **Thought** - Flow and form: no abnormality detected

8. **Perception** - Abnormalities detected

Orientation



9. **Memory**

- Intact

10. **Judgment**

Personal, social, and test judgments were intact.

11. **Insight**

Grade iv. Awareness about illness but blaming external factors.

Provisional diagnosis - OCD

Treatment plan

- **CBT:** CBT is a highly effective therapeutic method used worldwide in the treatment of a range of mental health conditions.
- **Medication**

Case Summary

The patient arrived at the hospital accompanied by his husband, presenting a range of chief complaints. These included irritability, fearfulness, anxiety, repetitive thoughts, aggression, difficulty concentrating, and a tendency to excessively wash hands and clean things. These symptoms had been persisting for the past eight years. Notably, there was no prior history of mental illness in the patient's family. During the mental status examination, it became apparent that the patient had obsessions related to cleaning, arranging, and ordering objects, and excessive hand washing. Additionally, the patient expressed anxiety regarding household tasks and reported a sensation of something being stuck in their throat. Based on these findings, the patient was ultimately diagnosed with OCD.

Treatment Approaches for OCD

Psychotherapy and medication are often used combined for effective treatment of OCD. Most people agree that the most successful psychotherapy strategy is cognitive-behavioural therapy (CBT), especially exposure and response prevention (ERP) (McKay et al., 2015). ERP is exposing people to anxiety-inducing stimuli—like filth or disorder—gradually while urging them to avoid their typical obsessive reactions. Through this approach, people might learn coping skills and lessen their need for obsessive behaviours to deal with their anxiety.

Apart from cognitive behavioural therapy, pharmaceutical interventions are frequently employed, especially selective serotonin reuptake inhibitors (SSRIs), which have demonstrated effectiveness in mitigating symptoms of obsessive-compulsive disorder (Fineberg et al., 2015). By increasing serotonin availability in the brain, SSRIs like sertraline and fluoxetine serve to

regulate mood and lessen the severity of compulsive behaviors and obsessive thoughts. For people with moderate to severe OCD, SSRIs and ERP frequently work best together.

Other choices for those who don't react to first-line therapies include more extensive interventions like Transcranial Magnetic Stimulation (TMS) and, in severe situations, Deep Brain Stimulation (DBS), or alternative drugs such as atypical antipsychotics (Stein et al., 2019). Advanced techniques like TMS and DBS try to rebalance the neural circuits driving obsessive-compulsive symptoms by focusing on certain brain regions implicated in OCD. Research shows encouraging outcomes for individuals who are not responding to conventional therapy, even though these treatments are often saved for severe cases (Greenberg et al., 2010).

Limitations

Despite this single-case methodology offering comprehensive insights, the particulars of the patient's history and symptom presentation may limit the generalizability of the findings to all OCD sufferers. A bigger sample size might improve the generalizability of results in future studies.

Conclusion

This case study demonstrates the intricate nature of obsessive-compulsive disorder (OCD) and how it profoundly affects a person's everyday functioning, mental health, and family relationships. The patient, a 52-year-old married lady, has typical signs of obsessive-compulsive disorder, such as compulsive actions, intrusive thoughts, a widespread fear of contamination, and frequent hand washing. In addition to interfering with her daily schedule, these symptoms also cause tension in her marriage, which is her main source of support and information. The eight-year symptom duration emphasizes how persistent OCD is and how it often lingers over time, particularly when treatment is inadequate or delayed.

The instance also shows that severe anxiety is frequently present in OCD, which encourages compulsions as coping strategies to lessen suffering. Even though these compulsions offer momentary solace, they eventually serve to strengthen the condition, resulting in a vicious cycle that is hard to escape. In this patient's instance, an intense fear of contamination was the driving force behind her frequent hand washing. The illogical yet alluring aspect of OCD is best illustrated by her conviction that she has to regularly wash her hands to get rid of imaginary germs. The patient is aware of the absurdity of her actions yet

feels unable to stop them, which reflects the internal struggle and frustration that people with OCD often experience. This obsessive-compulsive cycle is a substantial obstacle.

In addition to therapy, family members' and caregivers' assistance is crucial for managing OCD as they may support and reinforce treatment objectives. Her possible recovery in this instance is greatly influenced by the husband's participation as an informant and his comprehension of her situation. However, family members need to strike a balance between offering support and unintentionally encouraging obsessive habits. To guarantee that family dynamics favourably impact the patient's rehabilitation, mental health practitioners must provide information and guidance on this delicate balance.

References

- Abramowitz, J. S., Taylor, S., & McKay, D. (2009). Obsessive-compulsive disorder. *The Lancet*, 374(9688), 491-499. [https://doi.org/10.1016/S0140-6736\(09\)60240-3](https://doi.org/10.1016/S0140-6736(09)60240-3)
- American Psychiatric Association. (2013). *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.). American Psychiatric Publishing.
- Fineberg, N. A., et al. (2015). Clinical advances in obsessive-compulsive disorder: A position statement by the International College of Obsessive-Compulsive Spectrum Disorders. *International Clinical Psychopharmacology*, 30(2), 63-65.
- Goodman, W. K., Storch, E. A., Geffken, G. R., & Murphy, T. K. (2014). Obsessive-compulsive disorder. *Psychiatric Clinics*, 37(3), 257-267.
- Greenberg, B. D., et al. (2010). Deep brain stimulation of the ventral internal capsule/ventral striatum for obsessive-compulsive disorder: Worldwide experience. *Molecular Psychiatry*, 15(1), 64-79.
- Mathews, C. A., & Kaur, N. (2008). Treatment-resistant obsessive-compulsive disorder: Clinical features and treatment strategies. *Psychiatric Times*, 25(1), 1-7.
- McKay, D., Abramowitz, J. S., Calamari, J. E., Kyrios, M., Radomsky, A., Sookman, D., Taylor, S., & Wilhelm, S. (2015). A critical evaluation of obsessive-compulsive disorder subtypes Symptoms versus mechanisms. *Clinical Psychology Review*, 34(4), 201-210. <https://doi.org/10.1016/j.cpr.2014.12.002>
- Milad, M. R., & Rauch, S. L. (2012). Obsessive-compulsive disorder: beyond segregated corticostriatal pathways. *Trends in Cognitive Sciences*, 16(1), 43-51.
- Pauls, D. L., Abramovitch, A., Rauch, S. L., & Geller, D. A. (2014). Obsessive-compulsive disorder: an integrative genetic and neurobiological perspective. *Nature Reviews Neuroscience*, 15(6), 410-424.
- Stein, D. J., Costa, D. L., Lochner, C., Miguel, E. C., Reddy, Y. C. J., Shavitt, R. G., Van Ameringen, M., & Simpson, H. B. (2019). Obsessive-compulsive disorder. *Nature Reviews Disease Primers*, 5(1), 1-17. <https://doi.org/10.1038/s41572-019-0102-3>
- Torres, A. R., et al. (2011). Prevalence of obsessive-compulsive disorder in women with a history of trauma and posttraumatic stress disorder. *Journal of Anxiety Disorders*, 25(4), 493-499.