DOI: 10.7860/JCDR/2016/18633.7481

Case Report

Psychiatry Section

An Atypical and Resistant Case of Obsessive Compulsive Disorder Responding Satisfactorily with an Unusual way of Exposure and Response Prevention Therapy

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ABSTRACT

It is well established fact that a combination of pharmacological therapy plus cognitive behaviour therapy (CBT) - exposure and response prevention (ERP) is considered first line for the treatment of obsessive compulsive disorder (OCD). This case presented here supports this point in unusual way of ERP administration in an atypical and resistant case of OCD proved to be beneficial over pharmacotherapy. The case was atypical in the sense that it had many overvalued ideas, superstitions and religious beliefs playing major role in its aetiology. Also, misconstruction of chance associations, intense stimulus generalization and invivo exposure proving the best modality of treatment made it atypical.

Keywords: Cognitive behaviour therapy, Invivo exposure, Overvalued ideas, Religious-cultural beliefs and superstitions, Treatment resistance

CASE REPORT

A 22-year-old Hindu, male of lower socio-economic status, hailing from a rural background presented to the emergency department of a tertiary care hospital with symptoms of repetitive thoughts of contamination by ashes of cremated human dead bodies, fear and avoidance from black coloured objects, frequent washing of his hands and feet and bathing repeatedly for long duration. He was admitted and an elaborate physical and psychological evaluation was done during which patient revealed that 18 months back he went to attend a funeral ceremony of his relative and while the dead body burnt some of the ashes settled on him and other people. Few days later patient got the news that two of the people who had attended the funeral with him had suddenly expired. Patient became very distressed as he formulated a conception that the black ash which had settled on those persons and him, had led to their demise. He correlated the black coloured burnt wood present in his house for culinary purpose with the burnt pyres of the funeral and got extremely anxious. He threw all the logs out and cleansed his house repeatedly following which he bathed multiple times but this did not relieve his anxiety.

Gradually the intensity of distress and frequency of his washing and cleaning actions escalated. He became totally homebound and crippled due to his illness. He also prevented other family members from coming in contact with any black objects. He was facing and creating a lot of problems. There was prominent stimulus generalization related to anything 'black'. He started becoming fearful of black coloured cows, dogs, birds, stones, dresses, curtains and other objects. Thus with these findings he was diagnosed as a case of Obsessive Compulsive disorder (OCD) and was put on Tab. Clomipramine 50 mg at bedtime initially which was later titrated to 150mg, beyond which we couldn't increase the dose as patient started developing side effects. Tab. Flupenthixol and Clonazepam were also added as adjuvants but there was minimal response with all these drugs. We decided to go for CBT and we made a list of all the objects causing anxiety anddistress to the patient in a hierarchical way. We asked him to make mental image of the objects placed in the list and while doing so prior and after his vitals were monitored and Hamilton Anxiety Rating scale (HAM-A) was administered. Even the image of entity placed lowest in the hierarchy list would cause a lot of distress to the patient which was evident by deranged vitals and high HAM-A score.

Weeks after mental imagery he was exposed to black coloured wooden coal, ash and other objects with monitoring of vitals and application of HAM-A scale before and after each sessions. He gradually got habituated and could hold the ash without much discomfort. As days passed patient developed depression owing to the impact, the illness had upon his social occupational functioning, quality of life and family relationships. He developed suicidal ideations after which Tab. Sertraline (50mg) once bedtime was started which was later increased to 100mg daily. As there was not much improvement with imaginal exposure finally after discussing the condition of the patient with his attendants and obtaining consent both from the patient and his family members it was decided to take the patient to the cremation ground for invivo exposure. Initially the sight of the cremation ground caused intense anxiety and he had to be brought back following which he took bath multiple times for long durations (10-15times/day). These compulsive acts of washing and bathing were minimized slowly by reassurance and supportive psychotherapy. The field exposure continued each day.

Progress was calculated as how much nearer the patient can go to the funeral pyres and how long he can stay at the funeral ground. After 3-4 weeks of workup the patient could finally hold the ashes from funeral pyres without any distress and would not take bath for the whole night. He could also construct mental imagery and face the previous objects in vitro without any distressas evident by a low HAM-A score. He became more confident and had minimal anxiety and depression. He was finally discharged from hospital after a stay of 85 days with tab clomipramine (100mg) once bedtime and tab. Sertraline (50mg) twice daily. He was called for regular follow-up which he did, in which the dose of medicines

were adjusted adequately. It's been 1 year since then and the patient is doing well, is on medication and symptom free.

DISCUSSION

Obsessive–Compulsive Disorder (OCD) is characterized by presence of repetitive and persistent thoughts, images or urges which cause marked distress or anxiety (obsessions). The individual attempts to ignore or suppress these by repetitive behaviour's or mental acts in response (compulsions) [1]. Due to the significant amount of impact of OCD on life of a person WHO had listed it among 10 most disabling illness [2]. Although there are various modalities of treatment, a combination of pharmacological therapy plus cognitive behaviour therapy (CBT)- exposure and response prevention (ERP) is considered first line [3]. While maximum of OCD cases respond to these first line modalities of available treatment, some of the cases are found to be treatment resistant. Treatment resistant OCD patients are defined as those who undergo adequate first line therapies without achieving a response i.e. ≥25 or 35% decline in Y-BOCS score [4]. Among the patients with OCD, 40-60% usually do not achieve complete remission after first trial of drugs [5,6]. Even those who responded clinically have some baseline social and functional impairment due to their underlying symptoms [7]. The efficacy of psychotherapeutic augmentation in treating cases of resistant OCD has been demonstrated by various studies [8-10].

This report highlights an atypical and resistant case of OCD in whom unusual way of ERP administration proved to be beneficial over pharmacotherapy. The various atypical aspects of the case were, firstly it highlighted various over valued ideas such as ashes from a burning human dead body settling on body of other people were bad omen and religious belief and superstitions like evil spirit will cast its spell on whoever will come in contact with the ashes from cremation ground. Secondly there were also a lot of chance associations leading to unfortunate results like sudden death of two people who attended the funeral with the patient being misconstrued by him. Stimulus-response pattern was atypical andbizarre with intense generalizations. Ideas, thoughts and images related to the black wooden ashes which acted as initial stimulus became more generalized and intense and later encircled anything that is black. Finally real exposure to the cremation ground acting superior to any other modality of treatment also made the case atypical.

CONCLUSION

Management of treatment resistant cases of OCD still provide considerable challenge for any psychiatrist as management varies with each patient according to the phenomenology of the disease. The plan of treatment for each atypical obsessions and compulsions should be made after taking into consideration the associated socio-cultural factors which often plays a significant role in the development of the psychopathology. Hence, the treatment plan need to be flexible and evolve accordingly to provide maximum benefit to the patient.

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FINANCIAL OR OTHER COMPETING INTERESTS: None.

Date of Submission: **Dec 30, 2015**
Date of Peer Review: **Jan 24, 2016**
Date of Acceptance: **Feb 01, 2016**
Date of Publishing: **Mar 01, 2016**