Sociodemographic Details

Mrs. K.S. 51 years old Hindu female, educated upto post-graduation, homemaker married,belongs to MSES, nuclear family from Gwalior.

## Informants:

* + - Patient himself
		- Mr. A, employed in private company; Relationship: Husband; Duration of contact: 27 years

**Nature of Information:** Reliable and Adequate

**Source of referral:** The patient was referred to Gwalior Mansik Arogyashala by psychiatrist

**Purpose of referral:** psychological evaluation & therapy

from past 20 years but aggravated since last 4 years

## CHIEF COMPLAINTS

· **Doubt होता है कि यही कहा है मैंने या नहीं।**

· **बार-बार पूछती हूँ, doubt दूर करने के लिए।**

· **दरवाजा दिनभर चेक करती हूँ।**

· **चिंता होती है।**

· **मन उदास रहता है।**

· **कुछ करने का मन नहीं करता**।

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| --- | --- | --- | --- |
| **Onset** | **Course** | **Progress** | **Duration** |
| Insidious | Fluctuating | Deteriorating | 20years |
| **Predisposing Factors** | **Precipitating****Factors** | **Perpetuating****Factors** | **Protective factors** |
| Mother had OCD, brother had psychosis | Could not be elicited | no improvement from medicines, conflict with siblings andmother-in-law | Good insight |

## CASE SUMMARY

Mrs. K.S. 51-year-old Hindu female, educated till post-graduation, homemaker married, belongs to MSES, A nuclear family from Gwalior was brought to GMA OPD with complaints of obsessions related to doubt, compulsions to check, and reassurance seeking. The patient reported that she was maintaining well until 20 years ago. The patient reported that her mother-in-law demanded perfection and symmetry, often scolding her for not meeting these standards. The patient felt awkward witnessing her mother-in-law's behavior. Sensitive by nature, she was easily hurt and started feeling anxious about what might happen the next day. According to the informant, the patient's doubts began in 2005 when they moved to Gwalior, triggered by purchasing a new mobile phone. She suspected the shopkeeper had given her an old phone and, after an argument, decided to sell it. This behavior extended to other household items, which she would buy and then sell, doubting their quality.

Gradually, the patient started having doubts about whether she had locked the door, leading her to check it two to three times, especially after coming from outside or sitting in another room. Initially, she thought she was just being extra cautious, as she often forgot daily routine tasks. However, these habits persisted, increasing to 10-15 times per day. She also began doubting whether she had washed utensils and vegetables properly, washing them 5-6 times until she was satisfied. Her condition improved with medication, but during the COVID-19 pandemic, her doubts resurfaced. She had a troubled relationship with her sister and brother. When her brother, who developed a mental illness, came to her house for treatment, her distress level increased. Her brother said something negative about their elder sister, prompting the patient to say harsh words to her sister and niece. She felt extremely guilty and repeatedly called her

sister and niece to apologize, seeking reassurance that they had forgiven her. This behavior lasted for about a month. Eventually, her doubts shifted to her maid, suspecting that the maid was listening to her prayers and conversations. She began checking the door to see if the maid had entered and started asking others if she had said something that might have hurt someone. She believed that if she said something wrong, God would punish her. The informant reported that the patient sought reassurance 50-60 times daily about her actions or words. The patient felt exhausted from repeatedly checking the door and seeking clarification.

Her doubts about her sister and niece resurfaced after her father-in-law's death, intensifying during times of distress or sudden changes in her life. The patient also experienced conflicts with her mother-in-law, sister, and brother. Upon further inquiry, the patient revealed that she performed her compulsions out of fear that if she did not, God would punish her or something bad would happen. When these compulsions caused serious dysfunction in her life, she agreed to undergo psychotherapy. The informant consulted a private psychiatrist, seeking psychotherapy for the patient, as she did not gain much benefit from the medications and could not control her compulsions.

## BASELINE ASSESSMENT

Baseline assessment was done using Minnesota Multiphasic Personality Inventory (MMPI-II), International Personality Disorder Examination (IPDE), Rorschach Inkblot Test (RIBT), Sack’s Sentence Completion Test (SSCT), thematic perception test and Yales Obsessive-Compulsive Scale(Y-BOCS). The findings suggested that the patient feels socially uncomfortable and has poor social skills and judgment. The patient has prominent Borderline Personality traits and Dependent traits. She has some kind of atypical processing that involves more scanning shifts than is common. Her psychological consequences of the stress tend to be diffuse, impacting both thinking and emotion. She needs frequent reassurance and often finds it difficult to establish and maintain deep and meaningful relationships. The findings suggest that she has a need for frequent reassurance and often finds difficulty to establish and maintain deep and meaningful relationship. Consequently, this provokes self-examining behavior and can also cause internal conflict. The obsessions were doubt and concerned with morality reported and checking and seeking reassurance were of Contamination on the scale. She scored 29 which indicates the severe level of symptoms.

## PSYCHOSOCIAL FORMULATION

Mr. S.K., 26 years old Hindu male, educated until graduation, unemployed, unmarried, belongs to MSES, a nuclear family from Gwalior presented to GMA OPD with complaints of obsessions related to contamination, cleanliness, compulsions of cleaning and washing, and anxiety due to these obsessions and compulsions with an insidious onset, continuous course, deteriorating progress and duration of 3 years. a significant predisposing factor was his personality trait. Precipitating factors included an incident at work in place of the father in a government office where he observed his unhygienic coworker. Perpetuating factors included a lack of a disciplined routine, expressed emotion by family members, and not much improvement from medicine. Protective factors include good insight regarding illness. There is a significant deterioration in his personal, social, and occupational functioning.

**DIAGNOSIS:** ICD-10: F42.2 Mixed Obsessive and compulsive disorder

## MANAGEMENT PLAN

To manage the anxiety experienced by the patient as a result of obsessions, remove his compulsions and enable the patient to have a disciplined routine.

## TARGET AREAS OF THERAPY

|  |  |
| --- | --- |
| **SHORT TERM GOALS** | **LONG TERM GOALS** |
| Reducing his anxiety regarding obsessions | Improving social functioning |
| Reducing his time spent in compulsions | Improving distress tolerance ability |
| Function daily at a consistent level with minimal interference from obsessions and compulsions. | Accept the presence of obsessive thoughts without acting on them and commit to a value- driven life. |
| Sleep hygiene | Relapse prevention |
|  | Cognitive restructuring regarding faulty appraisals |
|  | Resolve key life conflicts and the emotionalstress that fuels obsessive compulsive behavior patterns. |

**THERAPEUTIC MODEL**

**Unwanted mental intrusion** Did I lock the door properly? Did I say abusive word right now?

**Trigger Stimulus**

Door, time of maid to come, doing prayer

**Reduced anxiety and increased perceived control**

A Cognitive Behavioural Model of Scrupulosity (OCD), Adopted from Abramowitz and Jacoby (2014) to the Mrs. K.S.

**Neutralisation and compulsion** Checking door 3-4 times Seeking reassurance

**Faulty appraisals and beliefs** “If the door isn’t locked, maid could listen to her prayer or maid listen her conversation. If I said anything wrong god will punish me one day.

**Increased Frequency**

**/ Salience**

## TECHNIQUE USED

* Psychoeducation
* Supportive psychotherapy
* Behavioural activation
* Exposure and Response Prevention (ERP)
* Cognitive restructuring

## No. of sessions: 28

**Duration of therapy:** 6 months

**Sessions in the week:** bi-weekly

## Therapy process

The whole therapy has gone through 3 phases: Initial, middle, terminal

## INITIAL PHASE (1-6)

The initial phase of therapy focused on establishing a therapeutic relationship with the patient and psychoeducating him about his diagnosis, probable causes, symptoms, and probable outcomes. The initial three sessions were dedicated to the same. The anxiety and its symptoms, for example, at physical and psychological levels, were explained to the patient. The anxiety graph and the cognitive-behavioral model (CBT) of obsessive-compulsive disorder (OCD) were introduced. The patient was attentive and cooperative. She cleared her doubts and queries then and there. After discussing the available treatment options, the therapist and patient mutually agreed to proceed with CBT. Once the patient was able to understand this, the therapist started to modify the patient’s interpretation of the obsession by normalizing the unwanted mental intrusions. The patient was relieved after hearing this. After providing many day-to-day examples, the client was able to understand the fact that distress is not caused by the obsession itself but by how it’s being interpreted. After this, the patient was educated on the role of faulty appraisals and neutralization in the persistence of obsessive-compulsive symptoms and associated distress. Two sessions were dedicated to the same. The patient was able to identify that neutralization resulted in counterproductive effects.

The patient was asked to maintain a diary and encouraged to self-monitor his obsessions, compulsions, and triggers; record thoughts, feelings, and actions taken; and routinely process the data to facilitate the accomplishment of therapeutic objectives. In a further session, the patient was explained about the cognitive-behavioral model (affect, behavior, and cognition) and how they interconnected and contributed to OCD symptoms. The patient was asked in the session to remember his life experience and create a CBT model. The patient made 3–4 examples and gave her own point of view.

In the next session, he was explained about ERP and how it would be used in treating her problems. The therapist also provides a rationale for treatment to the patient, discussing how treatment serves as an arena to desensitize learned fear, reality-test obsessional fears and underlying beliefs, and build confidence in managing fears without compulsions. The therapist assigns a patient homework to read and watch videos related to ERP. In the next session, the patient clarify his doubts related to ERP.

## MIDDLE PHASE (6-23)

The middle phase was dedicated primarily to using ERP as a therapeutic tool. Homework was given to count the number of times she checked the door and asked doubt. The informant was told not to give reassurance to the patient. The homework was partially completed. The patient did emotional venting about her disturbed relationship with her in-laws, marital problems, and her disturbed relationship with her sister, brother, and niece. She was told to do the anxiety graph activity for the next week. A hierarchy of anxiety evoking situations was made, and each of the items was recorded with the amount of distress produced (0 indicating none and 100 indicating severe incapacitating distress). Once the list was made and arranged in ascending order, the items causing 40% or more of the distress were selected for ERP. After describing the procedure of ERP, it was planned to expose the patient to doubts about whether I locked the door of her house. At the beginning, the informant was explained about the procedure of ERP using different examples and a demo in the hospital in front of the patient. The mutual steps of exposure were as follows: checking the door once before bed, checking the door and leaving the house for a short walk of 15 minutes, checking the door and driving away for 30 minutes, and checking the door and being away from home for several hours. The distress caused before exposure, at the start of exposure, and at the end of the exercise was recorded by the informant. Any disturbing thoughts, the need to perform the mental rituals, and any other remarks were asked to be recorded. The exposure was continued until there was a 50% drop in distress. The same is repeated until the initial exposure no longer causes 40% distress for the patient. The patient was given homework exercises to do ERP herself as well as make an anxiety graph to monitor anxiety during ERP at home. Also, write down any thoughts that came to mind while practicing ERP, any difficulties that the patient faced during practice, and the lessons learned during ERP at home. The patient was encouraged to delay his compulsion and explained the mindfulness techniques. The patient reported after continuing the session that the intensity of anxiety decreased and the frequency of checking decreased two times. This process also continued for reassurance, as her husband and son were told not to give her reassurance for a given period of time.

The patient also reported that she had problems talking to someone if she got lost in the middle and could not hear what the other person was saying. She was suggested activities to improve her attention, such as counting the stairs, tables of odd numbers, mandala art, and word puzzle games. In further sessions, the patient vented anger towards her elder sister, brother, niece, and mother-in-law. The empty chair technique was used to reduce her anger. She was asked to imagine her sister sitting in an empty chair in front of her and saying whatever she wanted to say. Homework was given to write about the problems she had with her brother, sister, niece, and mother-in-law and the thoughts she wanted to confront in front of them but didn't. The patient's homework was reviewed. Then the empty chair technique was used for confrontation with each one of them in further sessions. The patient reported that this helped her to understand her emotions and feel relieved after expressing her suppressed emotions.

Then, in a subsequent session, the therapist reviewed the goals of therapy. Patient ERP was started for door checking and reassurance-seeking behavior. The patient reported that she sometimes did resist her compulsion but sometimes forgot it, and her reassurance-seeking problem has decreased in intensity but was not completely cured. In the next session, new symptoms emerged. The patient reported that she had doubts about her maid and that she would hear her praying to Shri Mata Ji, even though she was not present in the house when the patient was praying. The patient was suggested to delay her doubt for at least 2–3 hours, then ask the maid only once. The informant reported that she asked 3–4 times continuously, even after stopping her. After that, the patient's previous doubts came, and she wanted to clear doubts for her sister and niece. The patient was encouraged to delay for 1 day. The patient reported that she wanted to call her sister. The patient was encouraged to use mindfulness techniques, distraction techniques, and different physical activity tasks. The patient reported a reduction in the intensity of her anxiety as her many doubts related to the maid, son, and sister disappeared, but her door checking and reassurance increased. In a further session, the patient was again psycho-educated about OCD, anxiety graphs, and treatment of OCD. The patient was encouraged to delay her compulsion. The patient reported that her frequency was also decreased, and anxiety disappeared in a short period.

Since the patient was making progress through ERP, the goal was turned toward behavioral activation for further sessions. The patient was asked for her master and pleasure exercises. After taking into account the exercises, the patient was told to maintain a diary in which she had to write her everyday schedule and rate each activity out of 10. After obtaining information from these activities, activity scheduling was done, and she was instructed to write it every day on an hourly basis. The patient's ERP continued until now, as her intensity and frequency of the highest SUD item also decreased to 60% overall.

## TERMINAL PHASE(11-12)

The objective of this phase was to summarize and discuss any concerns. Two sessions were given for the same. Because the patient had not achieved some of the of the therapy's goals. She reported that she wanted to continue her therapy. In the end, with mutual agreement, the therapy was transferred.

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## OUTCOME OF THERAPY

The patient was referred for assessment and psychotherapy. Her symptoms were obsessions related to doubts related to the door and the maid, reassurance, and anxiety due to these obsessions and compulsions. During the therapeutic process, the patient learned to manage her symptoms effectively and was confident in doing so. The assessment using Y-BOCS indicated her score was in the moderate range.

## FUTURE PLANS

* Re-start the goals if therapy is continued.