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Case Study

A Case Study of Severe Obsessive-Compulsive Disorder: Clinical Progress, Challenges, and Multidimensional Management

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ABSTRACT

This case study delves into the clinical journey of Mr. A, a 21-year-old man diagnosed with obsessive - compulsive disorder (OCD) at the age of 12. His symptoms gradually centered around contamination fears and compulsive cleaning, eventually escalating to severe thoughts of a sexual and religious nature, physical and verbal aggression, suicidal ideation, and social withdrawal. His study highlights treatment history which includes pharmacotherapy, Cognitive Behavioral Therapy and Exposure and Response Prevention (ERP). The paper additionally discusses how the efficiency of these therapies has evolved throughout the years. Despite persistent challenges with intrusive thoughts and social avoidance, his regular medication compliance and therapy participation led to significant improvement in symptom management and with family support. the study reinforces the value of modified Multidisciplinary approach to treat which demonstrate that even severe OCD cases can be managed effectively with the right therapeutic interventions.

Keywords: *Severe Obsessive-Compulsive Disorder, Clinical Progress, Multidimensional Management, Challenges*

Obsessive- compulsive disorder (OCD) is characterized by the occurrence of obsessions and or/ compulsions. It is associated with significant impairment, which is unlikely to remit in the absence of treatment (American Psychiatric Association, 2013). It is characterized by obsessions and compulsions which hinder key areas of performances or create clinically significant suffering. Obsessions are difficult to control, recurrent, intrusive thoughts, urges, or mental images that frequently have no purpose and are accompanied by distress or a bad mood. Repetitive behaviours that an affected person feels driven to carry out repeated in an effort to reduce the distress brought on by the obsessions or to avoid dreaded situation are compulsions.

The onset of OCD symptoms is bimodal. While most of individuals develop OCD symptoms in childhood, some on later age onset, with symptoms developing during adolescence or young adulthood. Males are somewhat more likely to exhibit the childhood-onset than females. Approximately, 2% of the population has reported experiencing OCD at some point during the life (Kessler et al., 2017).

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OCD may appear acutely, occasionally, or permanently (National Institute for Health and Clinical Excellence,2006). The phrase "chronic" essentially refers to the parameter however it makes no mention with the severity of an illness. On the contrary, if patient do not react to at least two appropriately dosed antidepressants drugs with unique active components, pharmacological treatment resistance to treatment.

Cognitive Behavioural Therapy (CBT) provides the strongest evidence foundation; its primary intervention are cognitive interventions Exposure and Response Prevention (ERP) or a combination these both. Over the years, ERP breaks the chain of obsession and compulsion by exposing patients to their afraid thoughts or situations without enabling them to engage in compulsive behaviours. In addition to provide academically essential, terminology- related queries are crucial essential for patient treatment. Using accurate description will make it easier to get accurate frequency data (Pallanti and Quercioli, 2006)

Therefore, current research aims to reinforce to strengthen therapy techniques, such as the creation of new pharmacological medicines and improved behavioural interventions and to get a deeper understanding of the fundamental causes of OCD and underlying the importance of tailored, multifaced treatment approaches or strategies.

METHODOLOGY

Aim

The aim of this study is to present an extensive case evaluation of Mr. A with sever OCD highlighting his clinical history, symptom progress, treatment plans and result. It also shows how well a multidisciplinary approach- medication, cognitive behavioural therapy, ERP and assessments can help to manage severe OCD.

Research Design

The clinical testing as well as therapy of Mr. A with severe OCD over a 12- year period is examined in this case study design using a qualitative, longitudinal methodology. Clinical records, psychometric tests (Y-BOCS, BDI), observation of therapy sessions, and interaction with patient were used to gather data. The study provides a thorough grasp of symptom management and patient growth over time through examining the impact of medication, Cognitive Behavioural Therapy, Exposure and Response Prevention and through assessment.

Tools & Instruments

Yale- Brown Obsessive- Compulsive scale (Y-BOCS)

Y- BOCS is often utilised scale by clinicians to gauge the intensity of compulsive and obsessive symptoms. Scores range from 0-40 for the 10 items on the test, which are rated on a scale of 0(no symptom) to 4 (severe symptom). OCD severity rises with high scores. The instrument was used to monitor changes in symptom severity at baseline mid treatment and post treatment to monitor in the severity of symptoms. In all clinical and research settings, the YBOCS has appear to have good validity and reliability.

Beck Depression Inventory (BDI)

The 21- item BDI is a self-report made to assess if or not sign of depression occur and just how serious they are. High overall scores suggest greater severity of depression. Every issue is evaluated on a scale from 0-3. Since depression can commonly co-occur alongside OCD, the BDI was utilised to evaluate sign of depression prior to and following treatment. The

BDI'S reliability and validity have been thoroughly demonstrated in both clinical and research context.

Exposure and Response Prevention

An established cognitive- behavioural therapy for obsessive- compulsive disorder (OCD) is exposure and response prevention or ERP. Its main objective is to subject the client to anxiety- inducing stimuli associated to their obsession (like contamination fear) and to stop the compulsive behaviours which come with it (handwashing). If clients frequently face these fears without acting in the desire, they gain habituation, that eventually minimises obsessive sufferings. With sessions typically lasting 60 to 90 minutes and comprising both in in-session exposures and course work, ERP is covered in a very organized way.

Y- BOCS Symptom Checklist

The specific type of compulsions (cleaning and checking) on obsessions (contamination and symmetry) as each patient experienced were classified with the Y- BOCS Symptom Checklist. Understanding the subtypes of OCD being treated was made possible by this category which guided the specific therapy plan.

CASE PRESENTATIONS

Case study: A Journey Through aggression and healing

Mr. A, a 22-year-old unmarried male, openly seek treatment within the Mental Health Act at a rehabilitation centre. He got diagnosed with OCD at the age of 12. He achieved most of his milestones for development as timeline, and a caesarean section was performed for the delivery. While though, he struggles academically and only reaches 40-50% of his skills, Amaan is characterized as quiet and reserved and open towards other people's emotion. During 2011- 2012, Mr. A experienced OCD symptoms, which were primarily marked by compulsive cleaning rituals prompted through contaminated anxiety. These symptoms increased through duration and developed having and enormous impact on his behaviour and interaction with people. His bodily rage including hitting his parents and breaking his laptop, was a sign of developing frustration and sadness. He also talked about having suicidal thoughts, include conversation regarding his sense of futility and ideas of death.

With his medical history his feelings of anxiety and mental turmoil are compounded that involves persistent, intrusive fantasies of a sexual and religious nature. In addition to withdrawing from friends and family through social avoidance, formed by feelings of paranoia, believing that others are talking against him behind his back. Reports of sleep difficulties likewise came out which has made further exacerbating his mental health struggles. In June 2024 Mr A, psychological condition got thoroughly evaluated over his brief time at AIIMS where he was admitted for further assessment due to his deteriorating symptoms.

The support and help of Mr. A's family was essential throughout the rehabilitation procedure. He was encouraged to remain fully engaged with the treatment process with their unwavering commitment to his wellness and his behaviour constantly demonstrated interaction and submission towards the centre's processes. His treatment results were significantly influenced by his positive attitude with a strong family foundation.

After being admitted, a series of assessments were administered to measure Mr. A's mental health and OCD severity. Using the Yale- Brown Obsessive Compulsive Scale (YBOCS) a

comprehensive assessment demonstrated various levels in severity, while the Beck's Obsessive- Compulsive Scale (BORS) indicated mild symptom severity. The complex nature of his issue was highlighted by his Y-BOCS symptom checklist, which provided into more detail regarding his compulsive behaviours and obsessive thoughts.

Throughout his journey, OCD has varied in strength from mild to severe. To manage with his intrusive thoughts and compulsions, his ongoing treatment consists of behavioural therapies like Exposure and Response Prevention and Cognitive Behavioural Therapy as well as medication and his family's constant backing played a crucial role in his treatment, which help him to stay motivated and active during the procedure.

Mental Status Examination: Mr. A demonstrated that while he appeared well groomed, he was clearly nervous and at times angry, particularly when addressing his unwanting ideas. He spoke clearly yet quickly, which was symptomatic of increased nervousness. He inhibited congruent affect, was agitated and nervous, broke down in tears when talking about suicidal thoughts. He had a rational way of thinking, but however he was overcome by paranoid thoughts about people talking about him and compulsive worries about aggression and infection. There were no reports of delusions or hallucinations. He was focused and attentive and while his memory was unharmed his anxiousness caused him to lose his focus. Despite his poor judgment during time to elevated anxiety, he showed good insight into his OCD.

Table 1 summarize the evaluation of Mr. A progress

SCALE	**EVALUATION**	**TREATMENT/ ASSESSMENT TOOLS**	**SCORES**
Symptom Severity	Fluctuated between mild and severe, particularly during time of stress.	Yale – Brown Obsessive Compulsive Scale (Y-BOCS)	Mild:12, Severe: 24
Aggressive behaviour	With treatment, the initial violent outburst decreased, however they still happen periodically	Pharmacotherapy & CBT	N/A
Intrusive thoughts	Through repetitive religious and sexual thoughts persist, ERP therapy has reduced these compulsions.	CBT (ERP)	Y-BOCS checklist, gradual reduction of compulsive behaviours.
Sleep And paranoia	Sleep Disturbances and paranoia about others discussing him persist, with sight improvements noted in sleep pattern	Pharmacotherapy	Improvement

SCALE	EVALUATION	TREATMENT/ ASSESSMENT TOOLS	SCORES
Insight	Good insight into his condition, understanding the impact of OCD in his life.	Clinical assessment	Good
Medication	Good adherence which prescribed particularly between 2014-2019 contributing to partial symptom.	Medication Management	Good adherence
Therapy Engagement	Actively engaged in ERP, with noticeable progress in resisting compulsions	CBT (ERP)	Good

Table 1 highlights the significant comprehensive evaluation of Mr. A progress and evaluation throughout his journey.

DISCUSSION AND CONCLUSION

The challenging and recurrent traits of obsessive-compulsive disorder, which developed in early adolescence and has progressed considerably over time, is brought to light throughout Mr. A's case. His condition initially presented as obsessive cleaning and contamination fears, but it gradually evolved to more severe symptoms including verbal and physical violence, suicidal ideas, and intrusive sexual and religious thoughts. His situation becomes more difficult by his social disengagement, paranoia, conviction that people are talking negative about him.

Despite of these challenges, Mr. A has showed positive treatment outcomes, particularly during medication and therapy, which resulted in a certain level of managing his symptoms. The Y-BOCS scores, varying from mild to severe show that his OCD severity shifts reflecting both periods of stable behaviour.

Mr. A understanding of his illness, which has stayed good and his regular participation in therapy, especially ERP are two of his key strength in his therapy journey.

In summary, since sever OCD cases are challenging to put into symptom reduction and long-term care tends to focus upon decreasing the severity of symptoms rather than the total cure. Mr. A's case highlights the value of a holistic approach towards treatment. Though, his positive therapeutic involvement and firm adherence to treatment provide a starting point towards progress. The support from family also plays a major role in his process, he seeks rehabilitation for the sake of his own and family which help him to cope better in his social difficulties also by interacting with others.

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Conflict of Interest

The author(s) declared no conflict of interest.

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