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Case Study

Exploring the Psychological Symptoms and Multidimensional Interventions Used for Obsessive-Compulsive Disorder: A Case Study

Disha Ghosh[1], Dr. Atreyee Bhattacharyya[2]*

ABSTRACT

Obsessive- Compulsive Disorder also commonly known as OCD is a chronic or long-term psychological condition. The disorder is characterized by the presence of obsessions and compulsions. Obsession are basically persistent, unwanted and intrusive thoughts, urges or mental images that causes anxiety, distress or fear as well on the other hand compulsions are repetitive or ritualistic behaviours or mental acts that are performed in order to reduce the anxiety. The disorder can be understood through depiction of behaviours such as fear of contamination, excessive checking, ordering, symmetry or intrusive thoughts of harm to oneself or to others. The main objective of the case study is to provide a comprehensive evaluation of the disorder, i.e., Obsessive-Compulsive Disorder (OCD), understand the case in an in depth level through evaluating the client's case history and presenting complaints and as a result developing a multidimensional treatment approach specifically tailored to the needs of the client presented in the case study. The study also depicts the important role of client's motivation and willingness as well as social support from family in improving the condition and better management of symptoms. The present case throws light upon Mr. S. B (pseudonym) who is a 35-year-old man who was diagnosed with OCD at the age of 20years. His predominant symptoms were fear of contamination, fear of harm and excessive cleaning behaviours. It can also be derived from the study that accurate diagnosis, consistent therapeutic intervention and family support acts as an essential factor in facilitating recovery. Multidimensional therapeutic intervention used in this case included Cognitive Behavioural Therapy (CBT) and Exposure Response Prevention (ERP) Therapy as an effective management of OCD symptoms and restoring daily functioning.

Keywords: *Obsessive-Compulsive Disorder, case study, Cognitive Behavioral Therapy, Exposure and Response Prevention, phenomenological approach, family support, fear of contamination, multidimensional treatment*

Obsessive-Compulsive Disorder (OCD) is one of the most prevalent psychological disorder that affects almost 1% to 3% of the global population, characterized by intrusive and unwanted thoughts, known as obsessions and performance of repetitive

[1]Student, Amity Institute of Psychology and Allied Sciences, Amity University Kolkata
[2]Assistant Professor. Amity Institute of Psychology and Allied Sciences, Amity University Kolkata.
ORCID: 0000-0002-2650-3787
*Corresponding Author

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actions, known as compulsions.

According to the American Psychiatric Association (APA) in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR), published in the year 2022, Obsessive-Compulsive Disorder (OCD) is defined as, a mental disorder marked by the presence of obsessions, which are persistent, intrusive, and unwanted thoughts, urges or images that causes distress, and compulsions, which are repetitive behaviors or mental acts performed in response to obsessions or rigid rules. Diagnostic criteria state that these obsessions and compulsions must be time-consuming (requiring more than one hour daily) or cause significant distress or impairment in functioning. The symptoms should not be due to substance use or another medical condition. The detailed definition and criteria are found in the DSM-5-TR, which is the standard guide for psychiatric diagnoses.

In the Diagnostic and Statistical Manual of Mental Disorder, Fifth Edition (DSM V), OCD is now defined separately from anxiety disorders and there is an increased emphasis on the role of or relationships to comorbid tics, hoarding, and poor insight.

There is growing support for novel dissemination methods for behavioral interventions (e.g., online-based therapy), pharmacologic approaches (e.g., neuroleptic augmentation of antidepressants), and neuromodulation (e.g., deep-brain stimulation) (Hirschtritt et al., 2017). These symptoms affect patients not only by consuming a significant portion of their time but also by resulting in marked distress and functional impairment.

OCD is a disorder which contains complex etiology involving factors from cognitive, genetic as well as neural, thus marking a challenging situation while diagnosis and a necessity to exclude other psychiatric conditions that might be present along with. Further complicating matters, OCD frequently coexists with other psychiatric disorders, requiring comprehensive identification and treatment for optimal clinical outcomes (Brock et al., 2024).

OCD is neurotic in nature and it is a type of anxiety disorder. OCD in most of the cases occurs during childhood, adolescence or early adulthood. Most people developing OCD occurs before the age of 25 years. OCD may be more common among males in childhood, but is more common in females in adolescence and adulthood. Males also tend to report and earlier age of onset and present with symptoms related to blasphemous thoughts. Females often describe symptom onset as occurring during or after puberty or pregnancy and present with symptoms related to contamination and/or aggressive obsessions (Mathes et al., 2019). OCD may appear acutely, occasionally, or permanently (National Institute for Health and Clinical Excellence, 2006).

OCD treatment might not lead to cure but it helps a person suffering from OCD to have control over one's functioning. Depending on the severity of the disorder OCD may require long-term or ongoing and intensive treatment. Basically, OCD can be treated mainly through two ways – psychotherapy and medication. Often, a mix of both treatment is also effective. Psychotherapy is also known as talk therapy, it involves – Cognitive Behavioral Therapy (CBT) and Exposure and Response Prevention (ERP) Therapy. In case of medication – Antidepressants and Selective Serotonin Reuptake Inhibitors (SSRIs) is mainly prescribed. As per the available research, ERP is considered as the first line evidence based psychotherapeutic treatment for OCD and the concurrent administration of cognitive therapy

usually targets specific symptom-related difficulties related to the characteristics of OCD, may improve tolerance of distress, symptom-related dysfunctional beliefs, adherence to treatment, and reduce drop out. Recommendations are provided for treatment delivery for OCD in general (McKay et al., 2015).

In addition to this psycho-education, is also largely helpful in treatment for OCD. Psycho-Education is defined as the process of providing education & information to those people who are seeking or receiving mental health services, such as people diagnosed with mental health conditions (or life-threatening/terminal illness) & their family members (EAP-India). Prolonged administration of Selective Serotonin Reuptake Inhibitors (SSRIs) is most effective. Better results can be obtained with a SSRI combined with Cognitive Behavioral Therapy (CBT) or the similarly oriented Exposure and Response Prevention (ERP) Therapy (Del Casale et al., 2019)

Therefore, this study focuses on the clinical diagnosis of Obsessive-Compulsive Disorder (OCD), case history suggesting a possible reason contributing to the development of the disorder and a multidimensional approach towards the cure or restoration of normal functioning in daily life, through a case representation.

Obsessive-Compulsive Disorder and related factors

Obsessive–compulsive disorder (OCD) is often linked to diminished quality of life (QoL) and impaired functioning. The study conducted by Coluccia et al. (2016), tried to identify which quality of life (QOL) domains are most affected in OCD may help guide targeted interventions. This analysis examined difference in global, work and social, family and emotional quality of life between individuals diagnosed with Obsessive-Compulsive Disorder and healthy control participants. It also investigated the moderating effects of age, gender, and OCD severity. Impairment were observed in QOL with moderate impairment in global QOL on the other hand severe impairments were observed in work, social, emotional and family domains. The study also depicted that female participants as well as participants with lower symptoms severity experienced more pronounced QOL as findings denote from the study between participants with OCD and control groups. Other psychiatric conditions were excluded through the use of meta-analysis. The findings thus emphasizes the need for treatment approach that looks into the QOL factor and emotional well-being. It has also been found that QOL interventions leads to benefits for women and individuals experiencing less severe OCD symptoms. Another study conducted by Asnaani et al. (2017), depicted improvement in QOL and functioning among participants who received Exposure and Response Prevention (ERP) Therapy than participants who only received medication, specifically risperidone. Relative to the placebo condition, Exposure and response prevention therapy showed superior outcomes in functioning, though not in overall QOL.

Across all treatment conditions, greater reductions in Obsessive–Compulsive Inventory–Revised (OCI-R) scores were associated with larger gains in QOL and functioning. Furthermore, Yale–Brown Obsessive Compulsive Scale (YBOCS) scores moderated changes in QOL such that participants with higher baseline symptom severity experienced greater QOL improvements over the course of treatment. It has been also sighted in the case depicted by Jahangard et al. (2018), where comparison with healthy controls, participants diagnosed with OCD demonstrated significantly less QOL scores and high levels of depression and anxiety. These differences were especially pronounced among female participants with OCD. Lower QOL remained evident among OCD patients even after

statistically controlling for depression and anxiety. According to logistic regression, analysis indicates that females tend to have lower QOL and higher levels of OCD, depression and anxiety symptoms collectively predicts OCD patient status. Therefore, individuals with OCD experience reduced QOL relative to healthy controls, and this effect persists independent of comorbid depression or anxiety. The impairment of QOL factor appears to be specifically high in female patients and findings suggested to consider the comorbid conditions and gender related consideration when addressing the QOL outcomes. Overall OCD symptom reduction were positively associated with both enhancement in QOL and functioning. Thus indicating an multidimensional approach to reduce symptom to achieve a broader functional recovery.

The accurate diagnosis of OCD is highly relied on the identification of specific symptoms and assessing the impact on the individual's daily functioning. These symptoms were found to be arising from the neurocognitive vulnerability that is rooted in neurophysiologically mechanisms. It has also been proved that doubt, uncertainty and lack of confidence are the central features in many cases of OCD, thus it becomes as important factor to examine their cognitive underpinnings. In the paper by Nestadt et al. (2016), the authors highlighted that OCD results from a disruption in the decision-making process and characterized reduction in confidence or certainty in integrating information that is required for making decisions. Insights into the cognitive vulnerabilities contributing to OCD is achieved thought the help of advances in neuroscience. OCD is also associated with morbidity and individuals diagnosed with this disorder tends to exhibit difficulties in decision-making and intolerance to uncertainty. The origin of this disorder as well as the mechanism of this disorder remains unclear. In the study conducted by Pushkarskaya et al. (2015), a validated behavioural economics choice task was employed in 20 unmedicated individuals with diagnosed OCD and 20 unmatched healthy controls, to examine the extent of value-based decision-making uncertainty. Responses received from the participants were analyzed to determine individual decision-making patterns. Findings revealed that individuals with OCD did not differ from control group in case of evaluating risky choices where probabilities were explicitly known, it was observed that they were more likely to avoid ambiguous options where outcome probabilities were unclear. It has been also found that individuals with OCD symptoms were less consistent in sticking to one choice and had greater difficulty in recognizing clearly preferable options. These abnormal behaviors were observed to be positively associated with symptom severity as well. Further investigation into the neural valuation network leads to enhanced understanding of neurocognitive mechanisms underlying OCD and makes it easier to highlight potential targets for therapeutic intervention. Recent research also focuses on the traditional anxiety-avoidance framework of OCD, suggesting that the disorder might also involve factors such as impulsivity, risky decision making and dysfunction in the reward system, indicates features that also depicts addiction. The exploratory study conducted by Grassi er al. (2015), examined this particular perspective by investigating whether individuals with OCD tends to exhibit three core dimensions, such as - greater impulsivity, impaired decision-making and biased probabilistic reasoning, these dimensions are also observed in case addiction, and these dimensions are then compared with health control group. A total of 38 individuals with OCD and 39 healthy control participants were evaluated using the Barratt Impulsiveness Scale (BIS-11), the Iowa Gambling Task (IGT), and the Beads Task in order to assess decision-making ability, impulsivity and probabilistic reasoning, respectively. Participants with Obsessive-Compulsive Disorder (OCD) scored significantly higher on the BIS-11 than healthy controls, particularly on the cognitive subscales. They also performed worse on the IGT, showing a preference for immediate

rewards despite long-term negative outcomes and demonstrating little adjustment following losses. In addition, OCD participants exhibited biased probabilistic reasoning, as indicated by making decisions after significantly fewer draws on the Beads Task compared with controls. Individuals with OCD appear to be more impulsive and display riskier decision-making patterns and biased reasoning compared to healthy individuals. These findings support the possibility of the behavioral addiction model to explain OCD would be better than the anxiety-avoidance model. Nonetheless, future studies that directly comparing OCD and behavioral addiction population, are mandatory to further evaluate this hypothesis.

The qualitative study conducted by Ali et al. (2015), explored the dynamics of familial and interpersonal relationships in the lives of individuals diagnosed with obsessive-compulsive disorder (OCD). Specifically, it examined how patients with OCD perceive the behaviors and attitudes of their parents, extended family members and siblings toward them. Through using a constructive paradigm as well as a collective case study design, the researchers investigated these relational patterns among patients with OCD. In this study, two participants were recruited from the Mayo Hospital in Lahore, Pakistan, through a homogenous purposive sampling strategy. Data collection was achieved using in-depth interviews, which included audio-recording, transcribed into Urdu and then analyzed using both the within-case and cross-case analysis. To ensure credibility the researchers addressed potential researcher bias and relied on rich and detailed descriptions. The findings revealed a close-knit relationship between patients and parents, on the other hand siblings were obligatory yet emotionally distant, along with that patients' interpersonal relationship with friends and cousins were reported as reciprocal and supportive. In another study, Solem et al. (2015), investigated interpersonal relationship styles among individuals with OCD. Inventory of Interpersonal Problems – Circumplex (IIP-C) was used by researchers to asses 101 outpatients with OCD undergoing Cognitive Behavioral Therapy (CBT). Findings revealed that patients with OCD tends to exhibit more interpersonal difficulties than people who are not diagnosed with OCD. Interpersonal style did not predict treatment outcomes related to OCD symptoms. As followed by CBT, participants depicted a mild to moderate reductions in interpersonal problems, which also remained stable at a 12-month follow-up. In spite of these improvements, individuals with OCD continued to display higher levels of submissiveness as compared to healthy control group. Findings suggests that interpersonal difficulties in OCD may be strongly associated with comorbid symptoms, particularly depressive symptoms, rather than being directly related to OCD symptom severity. Overall. Interpersonal relationship among individuals with OCD were relatively mild at baseline and did not significantly influence treatment response, although CBT was associated with modest improvements in interpersonal functioning. Walseth et al. (2017), explored the experiences of individuals with OCD through a focus group interviews, with the aim of understanding their relationship with their partners. Through the use of phenomenological approach, it was revealed that individuals with OCD maintains both emotional and physical distance with their partners. Participants reported that they felt they were being monitored and pathologized by their partners' accommodating or supporting behaviors, while also acknowledging their own tendencies to monitor their partners' compliance with compulsive rituals. The study further revealed that imbalances in power and control within relationships may persist even during periods of symptom improvement. Thus, suggesting emphasis on power dynamics and control issues in couple-based interventions for individuals with OCD.
Although individuals diagnosed with OCD often experience hostility and suspicious thinking, there has been limited research supporting these aspects. Tellawi et al. (2016), investigated the associations among hostility, suspicious thinking and OCD symptoms

severity. The researchers selected a sample which consisted of 161 participants, which consisted of 66 outpatients receiving treatment for OCD, 27 clinical outpatients with other psychiatric conditions and 68 non-clinical participants. Every participant completed the Inventory pf Hostility and Suspicious Thinking (HIS)— which is a measure of paranoid and psychotic like thinking, along the Obsessive-Compulsive Inventory – Revised (OCI-R), Beck Depression Inventory – II (BDI-II) and Beck Anxiety Inventory (BAI). Results indicated significant positive correlations between HIS scores and both anxiety and depression levels. Regression analyses further showed that participants with OCD exhibited higher hostility scores than the student group, and that hostility was positively associated with greater OCD severity. These findings suggest that hostility and suspicious cognitions are salient features within anxiety disorders, including OCD, and warrant further investigation.

There have been circumstances in which not all individuals with obsessive-compulsive disorder (OCD) achieve full symptom remission following cognitive-behavioral therapy (CBT), researchers have sought to identify variables that predict treatment outcomes. However, anxiety sensitivity (AS)—the fear of anxiety-related sensations due to beliefs about their potential harm—has not previously been examined as a predictor of CBT outcomes in OCD. Understanding the relationship between anxiety sensitivity and OCD is especially important for mainly two reasons. Firstly, several types of obsessive thoughts are closely associated with heightened sensitivity to anxiety-related sensations. Secondly, the individuals with elevated anxiety sensitivity may be more reluctant to participate fully in the anxiety-provoking components of Cognitive-Behavioral Therapy (CBT), particularly exposure-based interventions. In a study conducted by Blakey et al. (2017), 187 individuals diagnosed with OCD, participated in a residential CBT program. Participants completed self-report measures both before beginning treatment and after its completion. The findings showed that individuals who were more sensitive to anxiety at the start of the treatment tended to experience more severe OCD symptoms. More importantly, higher anxiety sensitivity at baseline also predicted greater symptom severity after treatment, even when initial OCD severity and depressive symptoms were taken into account. These findings highlighted the important role of AS in how OCD symptoms are present and how individuals respond to treatment. Similarly, the study conducted by Raines et al. (2015), investigated the relationship between OCD symptoms and insomnia, with particular focus on the mediating role of anxiety sensitivity (AS) cognitive concerns. The study included 526 participants recruited through Amazon's Mechanical Turk. Findings revealed that the "unacceptable thoughts" dimensions of OCD showed strong association with insomnia symptoms, and this relationship was partially explained by AS. Thus, suggesting that the cognitive components of AS may contribute to the frequent occurrence of OCD symptoms and sleep disturbances.

Clinical observations have long suggested that many individuals with OCD, experience pronounced feelings of guilt, a pattern often linked to overly strict superego. Despite of this clinical relevance, guilt has received relatively limited emphasis. In response to this, Geissner et al. (2022), conducted a study to examine whether individuals diagnosed with OCD experience higher levels of guilt compared to healthy individuals. The sample consisted of 100 participants including 34 male participants and 66 female participants, comprising 50 inpatients diagnosed with OCD based on IDCL criteria and 50 healthy control participants matched for age, gender and occupation. Guilt sensitivity was assessed using multiple measures, such as – Test of Self-Conscious Affect (TOSCA), Trait Guilt

Scale (TGS) and a newly developed scenario-based instrument (SIT), which included two subscales derived from interviews with patients and clinical experts. In addition, levels of depressive symptoms and OCD severity within the clinical group were measured using the Beck Depression Inventory (BDI) and the Yale-Brown Obsessive Compulsive Scale (Y-BOCS). The findings indicates that individuals with OCD reported significantly higher levels of guilt than healthy control group, particularly on the TGI and SIT subscales, whereas no significant difference were observed on the TOSCA. Participants with OCD also demonstrated elevate levels of depressive symptoms. Thus, indicating that guilt is a meaningful emotional component of OCD. Although earlier research has proposed that guilt may precede, motivate or arise from OCD symptoms, the precise nature of this relationship remains insufficiently explored. Studies examining trait guilt, or guilt propensity, have produced inconsistent findings and have not demonstrated its predictive value in OCD. Given evidence received through research conducted by Melli et al. (2017), demonstrated that individuals with OCD may perceive guilt as particularly threatening, it is important to investigate how the evaluation of the experience of guilt, referred to as guilt sensitivity (GS), takes place. In Study 1, the psychometric properties of a newly developed 10-item Italian measure - the Guilt Sensitivity Questionnaire, were evaluated in a nonclinical sample of 473 participants. Exploratory factor analyses supported the focus on one dimension of the scale, which has demonstrated excellent internal consistency and good discriminant validity. Study 2 examined the role of GS in OCD symptoms, particularly in relation to responsibility-for-harm obsessions and checking compulsions, using a heterogenous OCD sample (N = 61) and a control group of patients with anxiety disorders (N=47). Results indicated GS as a unique predictor of checking-related OCD symptoms, independent of negative mood and obsessive beliefs. Additionally, patients with responsibility-for-harm concerns scored significantly higher on the Guilt Sensitivity Questionnaire than patients with other obsessive concerns or anxiety disorders. These findings support the relevance of GS in OCD, especially when checking rituals are prominent, and have implications for cognitive-behavioral models of the disorder.

This systematic review conducted by Guzick et al. (2021), examined the effects of the COVID-19 pandemic on obsessive–compulsive symptoms. Evidence indicates that obsessive-compulsive symptoms generally worsened during the early stages of the pandemic, particularly among individuals with contamination-related OCD, though increases were observed across other symptom dimensions as well. Both patients and members of the general population reported new obsessive–compulsive-like behaviors related to COVID-19. Notably, studies that recruited participants from specialty clinics reported lower rates of symptom exacerbation and COVID-19-specific symptoms compared to online samples. Most research was conducted during Spring and Summer of 2020. The COVID-19 pandemic, has been a significant source of stress for many individuals with OCD, particularly those experiencing contamination-related obsessions. Despite these concerns, existing evidence indicates that standard, evidence-based treatments for OCD have contributed to be effective. Ensuring that such treatments remain accessible and widely disseminated therefore continues to be an important public health priority. While frequent handwashing was strongly promoted as an essential preventive measure during the pandemic. However, its impact on individuals with OCD who were already experiencing contamination fears and compulsive washing behaviors were initially unclear. To address this, Chakraborty & Karmakar (2020), examined the effects of the COVID-19 pandemic on individuals with OCD characterized by contamination obsessions and washing compulsions. Telephone interviews were conducted with 84 individuals who had a prior diagnosis of these

symptoms. The Yale Brown Obsessive Compulsive Scale (Y-BOCS) was administered and post-pandemic scores were compared with their pre-pandemic baseline levels. The findings revealed that only five patients (6%) experienced a worsening of symptoms following the onset of the pandemic, while the majority reported no significant change. The implementation of increased handwashing protocols during the COVID-19 pandemic did not intensify washing compulsions among OCD patients, nor did the fears of COVID-19 contamination amplify preexisting contamination related obsessions.

Although depressive symptoms commonly co-occur with OCD, the direction and nature of their relationship overtime remained unclear. Rickelt et al. (2016), explored the longitudinal association between depressive and OCD symptoms using data from the Netherlands Obsessive Compulsive Disorder Association (NOCDA) study. The sample consisted of 276 participants with a lifetime diagnosis of OCD, were assessed at baseline and again after one year using the Beck Depression Inventory (BDI) and the Yale-Brown Obsessive Compulsive Scale (Y-BOCS). Cross-lagged panel analyses indicated that higher levels of depressive symptoms at baseline significantly predicted greater OCD symptom severity at follow-up. In contrast, baseline OCD severity did not predict later depressive symptoms. These findings were consistent across subgroups based on comorbid major depressive disorder (MDD) status and the sequence of onset of OCD and depression. Overall, the results suggests that depressive symptoms may play an influential role in shaping the course of OCD, independent of comorbid MDD diagnosis or onset order. A recent review conducted by Pastre et al. (2025), aimed to examined contemporary perspectives on the high comorbidity between OCD and MDD, integrating both clinical and mechanistic viewpoints. The review aimed to identify insights relevant to treatment planning. While biological factors play a role in the development of OCD-MDD comorbidity, this overlap appears largely driven by the interacting symptom patterns that complicate the clinical course of OCD. Evidence suggests that combining both cognitive-behavioral therapy (CBT) programs tailored to depressive symptoms with selective serotonin reuptake inhibitor (SSRI) treatment may be particularly beneficial for individuals with moderate to severe comorbid presentations. The review emphasizes the clinical and diagnostic importance of OCD-MDD comorbidity, while noting that the underlying mechanisms remain insufficiently understood. The authors highlighted the potential value of future research—especially studies utilizing network analysis—to better identify and target specific symptom dimensions contributing to this overlap. Goodwin (2015) further demonstrated that anxiety disorders encompass a range of conditions, including generalized anxiety disorder, specific phobia, social anxiety disorder, agoraphobia, and panic disorder. Although each disorder has distinct diagnostic features, individuals often share overlapping symptoms such as heightened anxiety and emotional distress. This overlap is likely to reflect shared dimensions of distress of negative affectivity, supported by common genetic vulnerabilities and neuro-biological mechanisms. Although evidence for genetic overlap derived from twin studies, shared neuro-biological processes can be examined more directly through behavioral assessments of emotional or cognitive biases, as well as functional neuro-imaging techniques. These intermediate phenotypes offer valuable insight into the underlying mechanisms of anxiety disorders and can guide the development of more targeted pharmacological and psychological interventions.

Spencer et al. (2022), describe OCD as a condition marked by the presence of obsessions, which are unwanted, intrusive thoughts, images or impulses that causes significant anxiety or distress and compulsions, which are repetitive behaviors or mental acts performed in order to reduce distress or prevent feared consequences. OCD has an estimated lifetime

prevalence of approximately 1% to 3%, and individuals with the disorder frequently present with comorbid psychiatric conditions. The Yale Brown Obsessive Compulsive Scale (Y-BOCS) and the revised version of the Yale Brown Obsessive Compulsive Scale (Y-BOCS-II) are widely regarded as the gold standard instruments for assessing the presence and severity of OCD symptoms in adults, while another corresponding pediatric measure (CY-BOCS-II) has been developed for use with children and adolescents. Individuals experiencing OCD symptoms often experience marked difficulty across various domains of life such as social, occupational and familial domains, which also leads to reduced quality of life, difficulty in interpersonal relationships, work related challenges and an increased burden on family members. Given the significant distress and functional impairments in OCD, it becomes necessary to formulate effective intervention approach. Cognitive Behavioral Therapy (CBT) is widely recognized as the first line psychotherapeutic intervention for OCD, supported by strong theoretical foundations and extensive empirical research. CBT also includes Exposure and Response Prevention (ERP) Therapy and Cognitive Therapy (CT), both of which demonstrated effectiveness in treating OCD. However, findings across studies are not always consistent, largely because of variation in sample. In a comprehensive review, McKay et al. (2015), examined meta-analytic evidence on ERP and CT and evaluated their long term outcomes. The review identified ERP as the most preferable psychotherapeutic intervention for OCD. It also suggested that CT that targets maladaptive beliefs and disorder- specific cognitive processes may improve distress tolerance, reduce dysfunctional thinking, enhance treatment adherence and lower dropout rates. Recommendations emphasized the adaptability of ERP and CT across both general clinical practice and specialized treatment setting. Evidence suggests that ERP Therapy as generally sustained over time. Further support for ERP results from the meta-analysis by Song et al. (2022), which evaluated the effectiveness of ERP in comparison with various control conditions and examined differences across ERP variants. The analysis consisted of 30 studies comprising of 39 randomizer controlled trials with a total of 1,793 participants.

The results demonstrated that ERP produced a significant overall reduction in OCD symptoms, with particularly strong effects when compared with placebo and pharmacological treatments. However, ERP did not significantly outperform other effective psychotherapeutic interventions. Both the therapist-guided ERP and structured self-managed exposure approaches were associated with greater symptoms improvement, as was the comprehensive response prevention. Thus, suggesting that ERP leads to a modest reductions in comorbid depressive and anxiety symptoms. Similarly, Mao et al. (2022), conducted a systematic review and meta-analysis to assess the effectiveness of ERP with pharmacological treatment for OCD. A total of randomized control trials including 1,113 participants. Yale-Brown Obsessive Compulsive Scale (Y-BOCS) has been used as the primary outcome measure. Findings revealed that ERP combined with standard pharmacology such as Selective Serotonin Reuptake Inhibiters (SSRIs), clomipramine and risperidone, resulted in significantly greater symptoms improvement compared to medication alone. In contrast, evidence supported that addition of D-cycloserine (DCS) did not enhance the effectiveness of ERP. Therefore, suggesting that combing ERP along with pharmacological treatment depicted better managing of symptoms and proved to be durable.

Objectives

The main objectives covered in the present study, includes:

1. To understand the psychological symptoms experienced by an individual diagnosed with Obsessive-Compulsive Disorder(OCD)

2. To uncover the interventions that were used to manage these symptoms.

METHOD

Study Design

To meet the objectives of the study, a combination of descriptive phenomenological methodology and the case study approach was employees as the primary research frameworks. The descriptive phenomenological approach is a qualitative method aims to understand and describe individual's lived experiences of a particular phenomenon, with a strong emphasis on their subjective perceptions. This approach seeks to minimize researcher bias and avoid imposing preconceived theoretical interpretations. This methodology is rooted in the philosophical work of Edmund Husserl and later developed by Amedeo Giorgi, involves gathering detailed first-person accounts, typically through in-depth interviews or reflective narratives, and systematically analyzing them to identify recurring themes and core meanings. The outcome is a synthesized description that reflects the essence of the experience as lived by the participant.

For diagnostic and clinical understanding, the case study method was also utilized. This approach draws on multiple sources of information, including qualitative and, when relevant, quantitative data such as interviews, direct observation, and document review, to develop a comprehensive and contextualized understanding of the individual. Case studies are particularly useful for examining complex psychological conditions within real-life settings, as they allow for an in-depth exploration of symptom patterns, underlying processes and therapeutic outcomes. However, it is acknowledged that conclusions drawn from a single case may have limited applicability to wider populations.

Data collection involved several qualitative techniques. Information was gathered through structured, semi-structured, and unstructured interviews to explore the client' thoughts, emotions and behavioral patterns related to the disorder. Along with this, naturalistic observation, was used to directly assess the client's behavior and emotional responses without experimental manipulation, allowing for an authentic understanding of symptoms and interpersonal interactions. Relevant written records and personal documents were also reviewed to supplement and corroborate information obtained through interviews and observation. For the ensuring of accuracy of data and promote the client's comfort, all assessment sessions were conducted in a supportive, private and confidential setting. Rapport was established prior to formal assessment to encourage openness and trust. The Case Report Format (CRF) was systematically followed to ensure consistency and completeness in data collection. The CRF included detailed information on presenting concerns, personal and medical history, previous illness, family background, educational history, hobbies, sexual history and marital history. Further, a Mental Status Examination (MSE) was performed based on behavioural observations to assess the client's cognitive, emotional, and psychological functioning.

Case description

The case highlighted in this paper, involves a 35-year-old married male, who lives in a rural area near Nadia district within West Bengal, India. The client belongs from a Hindu family and reported that Bengali is his mother tongue. He has an educational qualification of an undergraduate and presently works as an employee in a cooperative bank as well as owns a hardware business. He belongs to a joint family with his parents, wife, daughter and younger sister. The primary sources of family income are the client and his father.

The client's wife, Mrs. R. G. B., informed about the symptoms of the client reported that the symptoms were observable since 2014 and also symptoms increased over the last two and a half years.

Demographic Details

The present case of Mr. S. B., reveals that he is a 35-year-old Indian male, who was seeking help of an expert regarding his discomfort or complaints in appropriate functioning in different spheres of his life. He reported of belonging to a Bengali family, residing in a rural area of West Bengal, India. The client also reported of belonging to a joint family structure, which includes his parents, wife, daughter and younger sister. This family arrangement effectively provides both emotional and instrumental support, reflecting the collectivist cultural values commonly observed on rural Indian communities. Mr. S. B., had an educational qualification of an undergraduate and was involved in dual occupations, which includes his job as an employee in a cooperative bank and as an owner of hardware business. From the information a stable socioeconomic background of the client can be considered. However, his family members reported concerns related to persistent repetitive thoughts and behaviors, which ultimately led to his referral for psychological assessment and intervention.

Mr. S. B., was clinically diagnosed with Obsessive-Compulsive Behavior (OCD) at the age of 20-years. Initially his symptoms were mild and involved excessive hand and feel washing and tendency to avoid eating outside food. Overtime, these symptoms intensified and began to interfere significantly with his personal, social and occupational functioning. The current evaluation was undertaken to gain a clearer understanding of his psychological functioning, symptom profile, and potential areas for therapeutic intervention.

Clinical Findings

Mr. S.B's presenting complains and the data extracted by the therapist indicates a fluctuating nature of his symptoms and their impact across multiple domains, therefore for better comprehension and insight a session-wise evaluation has been presented as follows:

Session 1: Initial Assessment

The client was brought by his wife with presenting complains stating, repeated handwashing and feet-washing, tendency to avoid eating outside food, anger outburst which are manifested in the form of verbal abuse to family members, physical aggression towards spouse, throwing objects, easily irritated and anxious, reduced appetite, sexual interest and energy levels. The mode of onset of the illness has been gradual and continuous since 2014, with a noticeable worsening of symptoms over the past two and a half years. He complains of feeling tired almost regularly. He frequently reports excessive tension, forgetfulness, and a general slowing down in daily activities. At times, he has shown episodes of unconscious toileting. While describing his distress, the client stated, "I feel lethargic and do not feel motivated to do any work", "My hands don't feel clean even after washing again and again", and also expressed a strong belief that "If I don't wash properly, something bad will surely happen to me". He also reported feeling anxious all the time, saying, "My mind never feels calm". His anxieties are mainly related to the intrusive thought related to fear of contamination and harm to oneself. His overall functioning appears to be affected, which have led to significant distress in both his personal and marital life.

During the initial mental status examination, the client appeared unkempt and guarded, with poor eye contact and a suspicious attitude. His psychomotor activity was rigid and responses were delayed. Subjectively his mood has been persistently low, stated by him that, "My thoughts don't stop, and I keep feeling tense". In a positive viewpoint, there was no perceptual disturbances noted.

Session 2: Exploring Symptoms in detail and Extraction of Case History

In the second session, the client was probed to elaborate on his contamination fears, particularly related to behaviors and thoughts after returning home from outside and while eating food from outside. He described that he felt a temporary relief after repeatedly washing his hands and feet, followed by intense anxiety. He stated thoughts, saying, "After coming home from outside, I feel dirty and only washing helps for some time". He faced anxiety not only because of his intrusive thoughts regarding fear of contamination and harm but also because of the existing suspiciousness towards his colleagues in his office, reporting that, "People in my office talk behind my back" which resulted in excessive stress, mistrust and avoidance.

In terms of treatment history, the client was earlier prescribed medication for cholesterol but discontinued it after one to two months. He also reportedly suffers from fatty liver and acidity but is not currently under any medical treatment. His past medical records indicate a history of jaundice lasting three years and a gastric problem for which he was hospitalized in Bombay during his mother's surgery. In 2014, he reportedly received psychiatric treatment for mental health issues related to anxiety and sexual problems. Regarding his family history, he belongs to a joint family structure. Some of his relatives suffer from physical illnesses such as hypertension and diabetes. The client also reported of occasional cigarette smoking among his family members and some of his family members also depicted mild forgetfulness, however there has been no such presence of psychiatric illness diagnosed among his family members. The client's personal history revealed a normal birth and appropriate achievement of developmental milestone, with no significant complications. In case of his academic history, the client reported of being an average student who had limited interest in the field. His schooling was completed in 2010 and started attending college from 2011 but discontinued in 2014 because of his preference for sports. During childhood, he experienced extreme fears of insects, snakes and water which led to avoiding of activities such as swimming, diving and others related activities. He also exhibited behavioral difficulties including temper tantrums and a tendency to throw objects when angry. He also reported of having a small group of friends. With regards to his occupational history, the client began his career in the year 2019, when he was of 28-years-old and is currently employed in finance related position in a cooperative bank with no significant change in his job as well as position. As reported by him, his work performance has been adequate, however, he reported of experiencing stress because of his perception that involves thoughts about exploitation towards him by the office colleagues and believes that others receive unfair advantages. The interpersonal and social history reveals that the client's marriage had been arranged by his relatives, and he had major adjustment problems with his wife, and primarily on the factor of sexual dissatisfaction. The client is also highly selective in regard to his interactions and prefers limited engagement, maintaining contact with friends and family only when necessary. He avoids social gatherings and prefers isolation. No legal history or involvement in criminal activity has been reported.

In the subsequent session, the client appeared slightly more cooperative, though anxiety remained prominent. His mood was same as previous, i.e., depressed and anxious, with restricted effect. Thought process were coherent but ruminative in nature. He continued to report intrusive thoughts, saying "My mind keeps going back to the same thoughts again and again". Attention and concentration have been impaired as he reported, "I try to focus, but my mind doesn't stay in one place".

Session 3: Reports related to emotional distress and impairment in functioning

In the third session, the client reported the worsening of emotional distress, irritability and difficulty controlling anger, which lead to a negative impact in his family relationships. He also acknowledged feeling of guilt after aggressive episodes and expressed emotional exhaustion, stating, "I get angry very fast, small things makes me feel annoyed and later I feel guilty for my behavior". He verbalized his feeling related to hopelessness and helplessness and passive suicidal ideation emerged, as he stated, "Sometimes I feel everyone would be better without me", and "I don't see any future for myself". These statements significantly indicated impaired emotional regulation and coping abilities.

During the third session, the client's mood was anxious and irritable, and emotional reactivity was heightened. Thought content involved feelings of guilt, worthlessness and passive suicidal ideation. He reported, "I feel like I have failed as a person" and expressed the difficulty to manage emotional distress, stating, "Even small things make me very tense". As comprehended, he has proper insight into his illness, though judgement was impaired during periods of heightened anxiety.

Session 4: Improving insight and Readiness for intervention

In the fourth session, the client demonstrated an improvement related to insight into his condition and acknowledged the excessive nature of his thoughts and behaviors. He also depicted a recognition regarding his inability to control compulsions despite awareness, stating, "I know my washing is too much, but I can't stop myself". He expressed motivation toward receiving treatment and also showed a keen desire for recovery, reporting, "I want to reduce these thoughts" and "I want to feel happy and want everything to be normal like before". This session mostly reflected the increased willingness to engage in therapeutic intervention.

In the final assessment session, the client showed improved eye contact and engagement. His mood remained anxious but was comparatively more stable. Thought processes were logical and goal-directed and the paranoid ideation was less than before. From the therapist perspective regarding his state, judgement can be made as fair with improved self-awareness.

Intervention Procedure

Mr. S. B's therapeutic journey demonstrated fluctuation and variation from mild to severe. In response to these varying levels of distress, a multidimensional treatment approach was implemented, with Cognitive Behavioral Therapy (CBT), Exposure and Response Prevention (ERP) Therapy and active family involvement as the core intervention strategy. The treatment was implemented in a structured and gradual manner, taking into account the intensity of symptoms as well the client's capacity to tolerate distress. The primary goals of therapy were to address maladaptive thought patterns, reduce compulsive behaviors and enhance emotional regulation.

Cognitive Behavioral Therapy, abbreviated as CBT, is structured, goal-focused form of psychotherapy that assists individuals in managing psychological difficulties by identifying and modifying unhelpful thoughts and behaviors. It focuses on the relationship between thoughts, feelings and actions to develop practical coping strategies and replacing irrational beliefs with more balanced and adaptive ways of thinking. In case of CBT, techniques used such as *cognitive restructuring*, *de-catastrophizing and thought monitoring and thought records*. Cognitive Restructuring involves identifying, challenging, and modifying distorted, irrational/ maladaptive thoughts that maintain OCD symptoms. For example, Mr. S. B. frequently reported intrusive thoughts related to contamination, such as "If I do not wash my hands repeatedly, I will definitely fall sick." These thoughts were identified as maladaptive thoughts that increased his anxiety and reinforced compulsive handwashing. During cognitive restructuring, the therapist helped Mr. S. B. examine the evidence for and against this belief. He was guided to recall instances where he did not immediately wash his hands and no illness or harm occurred. Through Socratic questioning, the therapist challenged the overestimation of threat and catastrophic thinking underlying his obsession. The thought was then reframed into a more balanced alternative belief: "Not washing my hands repeatedly does not mean I will fall sick; discomfort and anxiety will reduce on their own." With continued practice, cognitive restructuring gradually helped to reduce Mr. S. B's anxiety and intensity of compulsive urges, leading to an improvement in his daily functioning. A specific strategy used known as de-catastrophizing, which is a cognitive restructuring technique aimed at challenging the belief that minor risks inevitably result in severe outcomes. For instance, Mr. S. B. frequently reported of a catastrophic thought: "If I eat food which are not washed properly, I will become seriously ill and something terrible will happen." This belief led to triggering of heightened anxiety and led him to avoid certain food altogether. In this case, de-catastrophizing technique was used and the therapist supported Mr. S. B. in examining the feared outcome by exploring the worst-case scenario, the most realistic outcome and his capacity to cope. He was encouraged to recall previous instances in which he had eaten food without excessive washing and did not experience any serious illness. As a result, Mr. S. B gradually realized that even if minor discomfort were to occur, it would be temporary and manageable rather than catastrophic. The thought was restructured into a more realistic appraisal: "The chances of something severe happening is very low, and even if I feel unwell, I can cope with it." This helped reduce anticipatory anxiety and decreased avoidance and compulsive behaviors. Thought monitoring helps client to become more aware of automatic negative thoughts and understand how these thoughts triggered anxiety and compulsive behaviors and gradually replacing them with a more balanced thought. Thought records consists of a structured written format used to examine challenge these thoughts. For example, Mr. S. B. was asked to monitor situations that triggered anxiety and compulsive behaviors during the day. He noted that his anxiety increased mainly before meals and after returning home from outside. After touching door handles, he noticed an automatic thought that his hands were contaminated and that failure to wash them would lead to harm to himself. This thought was accompanied by intense anxiety and resulted in repeated handwashing. Regular thought monitoring helped him recognize the consistent link between intrusive thoughts, heightened anxiety, and compulsive rituals. Using this awareness, a structured thought record was then applied to examine and modify these maladaptive thoughts. Mr. S. B. was guided to write down the triggering situation, his automatic thought, the intensity of the emotion, and the evidence supporting and contradicting the thought. He reflected on past experiences where he had touched similar surfaces without washing excessively and no harmful consequences followed. Based on this evaluation, the original belief was replaced with a more balanced

alternative thought, such as recognizing that anxiety does not necessarily indicate danger and that discomfort can reduce without compulsive washing. Over time, repeated use of thought records reduced his anxiety intensity and supported a gradual decrease in compulsive behaviors when combined with ERP therapy, Exposure and Response Prevention (ERP) Therapy is a type of Cognitive Behavioral Therapy (CBT) that helps people with anxiety and Obsessive-Compulsive Disorder(OCD) by gradually confronting feared situations (exposure) while learning to stop performing compulsive rituals (response prevention), breaking the anxiety-compulsion cycle and retraining the brain to see threats as less dangerous over time. In case of ERP Therapy, techniques such as *in-vivo exposure* and *graduated exposure therapy* have been used simultaneously. In the graduated in-vivo exposure, the client was gradually exposed to feared situations, such as touching objects without washing his hands immediately, while being encouraged to resist the urge to perform compulsions. Initially, this caused intense anxiety, but over repeated sessions, his anxiety levels reduced, demonstrating habituation. For example, the client was asked to touch a door handle perceived as contaminated and delay handwashing for 5mins, which was increased to 10mins, 15mins, 30mins, eventually, based on the client's ability to tolerate distress and anxiety and repeated exposure led to effective reduction in anxiety levels.

DISCUSSION

The findings derived from the present case study shows that Mr. S. B demonstrated improved control over intrusive thoughts, better management of compulsive behaviors and improved daily functioning and enhanced quality of life. The client's regular engagement in the multidimensional therapeutic approach including Cognitive Behavioral Therapy (CBT) and Exposure and Response Prevention (ERP) Therapy, with a particular focus on the techniques such as cognitive restructuring, de-catastrophizing, thought monitoring and thought records. As a result, the client achieved an improvement in awareness about the maladaptive thought patterns and better tolerance towards anxiety-provoking situation, which eventually led to a reduction in frequency and intensity of compulsive behaviors, especially the repetitive hand and feet washing and voidance related to contamination fears. in addition, improvements were also noted in case of the client's emotional regulation and insight into his condition, along with that active involvement of family members played a supportive role by strengthening treatment adherence and motivation. Although complete remission could not be achieved, the overall outcome indicated a meaningful symptom control and better functional adjustment. Thus, emphasizing the value of comprehensive and individualized treatment approach in the management of Obsessive-Compulsive Disorder.

Mr. S. B's case also highlighted the persistent and evolving nature of OCD, which began in early adolescence and progressed over time. Initially, his symptoms were primarily characterized by compulsive washing rituals driven by fears of contamination and harm, however the symptoms showed gradual intensification, thus leading to a chronic and recurrent course of the disorder including verbal abuse and physical aggression, suicidal ideation along with severe adjustment problems with family members. His situation became more difficult because of his social disengagement, paranoia and conviction that people are talking negative about him, specifically his office colleagues. As a result of his condition, he had experienced problem in various areas of his life, majorly including his quality of life, decision-making process and interpersonal relationship. He had an experience of an impaired quality of life, characterized by disruption in normal functioning of life because of his preoccupation with obsessive thoughts and compulsive behavior (Coluccia et al., 2016; Jahangard et al., 2018; Asnaani et al., 2017). He also faced problem while taking firm

decision about personal and professional life, due to which he also developed the suspicion that his colleagues or senior members in workplace is against him along with that he was also unable to decide whether to continue his family business or focus in his job (Nestadt et al., 2016; Pushkarskaya et al., 2015; Grassi et al., 2015; Tellawi et al., 2016). He experienced adjustment problems with his wife and his parents, and there has been a tendency to isolate oneself from others, leading to lack of communication and problem-solving. He often demonstrated physical violence such as throwing household appliances, beating his wife, breaking things, etc., along with verbal abuse (Ali et al., 2015; Solem et al., 2015; Walseth et al., 2017). He had experienced suicidal thoughts and have been experiencing anxiety and depicted symptoms of depressive condition (Rickelt et al., 2016; Pastre et al., 2025; Goodwin, 2015). His condition got more worse after the pandemic in 2020, i.e., COVID-19, which lead to severe OCD symptoms (Guzick et al., 2021; Chakraborty & Karmakar, 2020). He also experienced guilt upon his actions, but as a result of his severe condition, he was unable to control the symptoms (Geissner et al., 2022; Melli, et.al., 2017).

Despite of these challenges, Mr. S.B., has showed positive treatment outcomes, particularly during therapeutic approach, which resulted in better management of his symptoms. Mr. S.B's insight about the illness has helped him with better management of symptoms along with that his family had also supported him in this journey and his regular participation in therapy, especially CBT and ERP became his key strength in his therapy journey (Spencer, et.al., 2022; McKay, et.al., 2015; Song, et.al., 2022; Mao, et.al., 2022).

Limitations

The study presented involves certain limitations which are acknowledged further. First, the findings are based on a single case-study, which limits the generalizability of the results to the broader population and secondly, certain external influences such as COVID-19, family dynamics, etc., and comorbid symptoms such as depression, anxiety, leads to difficulty in attributing improvements solely to the interventions used.

CONCLUSION

The case study highlights the complex and persistent nature of Obsessive–Compulsive Disorder and its significant impact on an individual's emotional, social, and occupational functioning through focusing on the presenting complains of the client. Mr. S. B's condition demonstrated in this present study effectively showcases the effect of untreated or partially managed OCD on the individual as well as his family members. Thus, leading to an emphasis upon early detection and comprehensive assessment to understand the nature of the disorder. The present study further emphasized on the effectiveness of the multidimensional treatment approach including Cognitive Behavioral Therapy and Exposure and Response Prevention Therapy, pharmacology and family involvement. These interventions have led to a contribution in reducing OCD symptoms and better insight generation. Although complete remission was not attained a steady improvement in overall functioning was observed.

Therefore, it can be concluded that this study fulfills the objectives, which are, to understand the psychological symptoms experienced by an individual diagnosed with Obsessive-Compulsive Disorder(OCD) and to uncover the interventions that were used to manage these symptoms.

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