Impact of Clinical Appraisal and Therapeutic Talk on OCD Patients: a Case Study

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Abstract:- In this study, we present a case of patient of a 51 year old female who own account of her OCD. In this paper her informant describes about Patients distressing knowledge. The effect of the disturbance on Patient and her family's life and her ensuing change utilizing the procedure of introduction and reaction avoidance,. OCD affects individual from job, relationship, belief, culture, society. The required information are collected from Gwalior Mansik Aaroygshala. This paper gives the historical backdrop of one such patient on OCD in accordance with the indicative confirmation for the situation.

Keywords:- *Obsessive compulsive disorder (OCD), case study.*

I. INTRODUCTION

In OCD, person have unwanted thoughts ideazations (obsessions) that make people feel compel to do something again n again (compulsion).Behaviour like washing hands , checking locks (things) that can altogether interfere with a individuals everyday standard and societal connection. Many individual have concentrated thoughts or repeated behaviours. But these don't effect on daily routine and may make task easier. For OCD patient, thoughts are determined and unwanted routines and behaviours are fixed and not doing them causes anguish. Individual with OCD know their obsession are not true they have a hard time keeping their focus off stopping the compulsive actions.

II. OBSESSIONS

Obsessions are intermittent and decided musing, driving forces, or picture that reason upsetting feelings, for example, anxiety. Numerous individuals with "OCD" perceive that the considerations, Obsession are a result of their psyche and are intemperate or outlandish. however, nosy thoughts can't be solve by rationale or thinking. A great many people with OCD endeavour to disregard or smother like obsession them with some different musings or activity. Run of the mill Obsessions incorporate inordinate worries about defilement or damage, the requirement for precision, symmetry, prohibited sexual or religious thoughts.

- *"By DSM 5 obsession are defined by:*

- Recurrent and persistent thoughts, urges, or images that are experienced, at some time during the disturbance, as intrusive and unwanted, and that in most individuals cause marked anxiety or distress.
- The individual attempts to ignore or suppress such thoughts, urges, or images or to neutralize them with some other thoughts or action (i.e. by performing a compulsion)."

III. COMPULSIVE

Compulsions are repetitive practices that man feels headed to perform in light of a obsession. The behaviour is focused for anticipating or decreasing trouble. In the intricate cases, a repeated of ceremonies may fill the day, making an ordinary routine unimaginable compounding customs cause is the learning that the compulsion are unreasonable. Despite the fact that the impulse may convey some helps to the stress, the obsession return and the cycle repetitively.

- *"By DSM 5 Compulsion defined by*

- Repetitive behaviour that person feels driven to perform in response to an obsession or according to rules that must be applied rigidly.
- The behaviour are aimed at preventing or reducing anxiety or distress, or preventing some dreaded event or situation; however these behaviour or mental acts are not connected in a realistic way they are designed to neutralize or prevent ."

- *Example*

- Mental compulsions (response to obsessive thoughts, some people silently pray or say phrasing to reduce anxiety.)
- Checking (reduce the fear of harming oneself or others by e.g. forgetting turn off the gas stove, forgetting to lock the door.)
- Ordering and arranging (reduce discomfort keep the book, things in a certain order or in symmetric order.)
- Repeating (dispel anxiety People do repetitions won't actually guard against injury but they have fear harm will occur if the repetition aren't done.)
- Cleaning (reduce that germs, dirt or chemicals will contaminated them some spend may hours by cleaning surroundings.)

IV. CAUSES

- Chemical and brain dysfunction: The chemical messenger, serotonin is by all accounts vigorously included. Serotonin is a chemical called neurotransmitter that permitted nerve cells to speak with each other by working in the space between nerve cell, called the synaptic separated. According to researches, serotonin is involved with biological processes such as

appetite, aggression, mood and pain. It is also seems that serotonin is capable of connecting to nerve cells in the brain in many different ways and so can cause many different ways and so can cause many different response . It is not likewise fully appear that serotonin chemical or another chemical entirely acting on it; or a malfunction in one or more of the receptors in the brain that serotonin joins to that causes the OCD issues.

- Genetics- Some research points to the childhood that OCD suffers will have a family member with the problem or with one of the other "OCD spectrum" of disorder.
- Infection: A streptococcal contamination of the throat is known to once in a while result in the body mistaking sound cells for the disease and causing cell harm. In the event that this has occurred with the cerebrum, the body's disease battling the mind with the outcome that OCD side effects happen. Some exploration proposes that these indications don't appear to last very long and the occurrence of this infection OCD seems to be very rare.
- Depression: People with depression sometimes develop OCD symptoms, and those with OCD very often develop depression. Dealing with both together is very difficult without clinical intervention and it is notoriously difficult to undertake an exposure programme while the depression is high.

➢ *Treatment / Cures:*

- Behavioural therapy is effective in treating most cases of OCD.
- OCD is treated using therapy and medications.
- Cognitive Behavioural therapy (CBT) has been shown to be the most effective type of psychotherapy for this disorder. The patient is exposed many times to a situation that triggers the obsessive thoughts, and learns gradually to tolerate the anxiety and resist the urge to perform the compulsion. Medication and CBT together are considered to be better than either treatment alone at reducing symptoms.
- Psychotherapy can also be used to: effective ways of reducing stress

➢ *Reduce anxiety*
➢ *Resolve inner conflicts*

- Your own description of the behaviour can help analyze the disorder. A physical exam can rule out physical causes, and a psychiatric evaluation can rule out other mental disorders.
- Questionnaires, such as the "Yale Brown obsessive Compulsive scale (YBCOS)", can help diagnose OCD and track the progress of treatment.
- The first medication usually considered is a type of antidepressants called a selective serotonin reuptake inhibitor " SSRI" .These drugs include :

1. Citalopram (Celexa)
2. Fluvoxamine (Prozac)
3. Fluvoxamine (Luvox)
4. Paroxetine (Paxil)
5. Sertraline (Zoloft)

V. INSIGHT

- OCD patient with fair insight the person think that OCD belief are exactly not true.
- OCD patient with poor insight person think OCD beliefs are probably true.
- OCD patient with absent insight / delusional person think are completely convinced that OCD beliefs are true.

VI. PREVALENCE

The year pervasiveness of OCD in the assembled States is 12 % with a comparable predominance universally (1.1%-1.8). Females are influenced marginally high than guys in adulthood, despite the fact that guys are all the more generally influenced in youth.

VII. DEVELOPMENT AND COURSE

According to DSM 5:

"In United States, the mean age of onset of OCD is 19.5 years, and 25% of cases start by age 14 years. Onset after 35year is unusual but does occur. Males have an earlier age at onset than females nearly 25% of males have onset before age 10 years. The onset of symptoms is typically gradual however, acute onset has also been reported.

If OCD is untreated, the course is usually chronic, often with waxing and waning symptoms. Some individual have an episodic course, and a minority have a deteriorating course. Without treatment, remission rates in adults are low (e.g. 20% for those revaluated 40 year later). Onset in childhood or adolescence can lead to lifetime of OCD. However 40% of individual with onset of OCD in childhood or adolescence may experience remission by early adulthood. The course of OCD is often complicated by the co occurrence of the other disorder.

Compulsion is more easily diagnosed in children than obsession is because compulsions are observable. However, most children have both obsession and compulsion (as do most adult). The pattern of symptoms in adult can be stable over time, but it is more variable in children. Some differences in the content of obsession and compulsion have been reported when children and adolescent samples have been compared with adult sample. These differences likely reflect content appropriate to different developmental stages (e.g. higher rates of sexual and religious obsession in adolescents than in children; higher rates of sexual of harm obsessions (e.g. fears of catastrophic events, such as death or illness to self or loved ones) in children and adolescents than in adults."

VIII. RISK AND PROGNOSTIC FACTOR

Temperamental More conspicuous manifestations, higher negative emotionality and behavioural in youth are conceivable fickle hazard factors.

Environmental Physical and sexual mishandle in youth and other upsetting accidents have been related with an expanded hazard for creating OCD, a few youngster, may build the sudden beginning of OCD side effects, which has been related with various environmental elements including different infectious against and a post irresistible immune system disorder.

Genetic and physiological the rate of OCD among first degree relatives of grown-ups with OCD is roughly two times that among first degree relative of those without the confusion; however among first degree relative of individual with this beginning of OCD in youth or puberty, the rate is expanded 10-overlay. Familial transmission is expected to some extent to hereditary variable more prominent symptoms, higher negative emotionality and behavioural in youth are possible temperamental risk factors.

- *Suicide risk*

Suicidal Thoughts happen eventually in the same number of as for portion of people with OCD. Suicide endeavours are likewise answered in up to one fourth of people with OCD; the nearer of co morbidity real depressive issue increment this hazard.

IX. CO MORBIDITY

According to DSM 5 "Person with OCD often have other psychopathology. Many adults with the disorders have a lifetime diagnosis of an anxiety disorder (76% e.g. Panic disorder, social disorder, specific phobia) or a depressive disorder with the most common being major depressive disorder or bipolar disorder, with the most common being major depressive disorder (41%) , onset of OCD is usually personality disorder is also common in individuals with OCD. later than for most co morbid anxiety disorder (with the expectation of separation anxiety disorder) and PTSD but often precedes that of depressive disorder. Co-morbid obsessive- compulsive.

Up to 30% of individual with OCD also have a life time disorder. A co morbid disorder is most common in males with onset of OCD in youth. These individuals tend to differ from those without a history of tic disorder in the themes of their OCD tic disorder and attention deficit/hyperactivity disorder can also be seen in children.

Disorder that occur more frequently in individuals with OCD than in those without the disorder include several obsession compulsion and related disorders such body dymorphic disorder, trichotillomania (hair pulling) and excoriation (skin picking) disorder. Finally, an association between OCD and some disorders characterized by impulsivity such as oppositional defiant disorder has been reported.

OCD is also much more common in individuals with certain other disorders than would be expected based on its prevalence in the general population; when one those other disorder is diagnosed, the individuals should be assessed for OCD as well. For example, in individuals with schizophrenia or schizoaffective disorder, the prevalence of OCD is approximately 12% Rates of OCD are also elevated in bipolar disorder; eating disorder, such as anorexia nervosa and bulimia nervosa and Tourette's disorder."

X. CASE PRESENTATION

Patient was apparently well before approx 18 year. She went to fort after her visit fort. She afraid of that place and did not sleep that night because she heard from the other the place was haunted the fort has many spirits. By that day, she avoids interactions and even can't sleep that night due to nightmares. During sleeping time if anyone tries to waking up her she got so violent, start afraiding, start talking irrational like pillows are in the air. She shows very aggressive behaviour toward her husband and children. She didn't take care of her children and her children. Day by day, she start spending more time in cleaning herself, washing, bathing. No one was aware about this illness so her husband starts getting violent toward her. By this day by day she start get involve into washing, bathing, cleaning activity. Her husband got so frustrated from her so he left her in her parents' house for 1 year. Later on, after 1 year by pressurize him by their parents he get back her. during this time, she reduces the activity of cleaning, bathing, washing activity. After approx. 6 months she again started spending more time in bathing, cleaning house. Then, she back to daily routine and start doing work i.e. she cook food then again start cleaning her house by wiper she didn't like to touch cloth, she use to wash utensils after cleaned by maid then again go to bathroom for cleaning herself where she took approx 4 hour. The time when she went for treatment to a Psychiatrist, she got some medicine by those medicine she got side effect like gaining weight, feeling drowning, once she got burnt her hand while cooking because of drowning. After this incident she left the medicine. She ate sweets. The medicine was continued for 5 month. From then to now, she got back to her activities. She got her spread bathroom, washing area, room, if any one try to use or use her thing she get irritated. She can't talk to anyone because she spend her whole time in this activities. Her husband doesn't like to welcome anyone to his house because her behaviour, all interpersonal relation is broken. She don't contact to anyone. Then she back to previous behaviour spending much time in bathing, washing, cleaning has increased. During this period her predominant mood was irritable didn't like to meet with new people. her personal hygiene was not maintained.

XI. BIOLOGICAL HISTORY

Her Father has Obsessive compulsive disorder. He like to do praying for minimum 3 hour per day. If someone stop him for doing praying or can't do by any reason he got irritate, feels disgust .Whenever, he got free he start spending time into praying he was in the habit of substance use (alcohol).

XII. PSYCHOLOGICAL HISTORY

She has some stress, as her interpersonal relations were not good because of her husband. As she doesn't have anyone to talk she became depressed.

XIII. PREDISPOSING FACTORS:

- *Biological-*

Patient's good health allowed her to stay away from any form of medical services that would noticed her swelling, bruised hands because of cleaning.

- *Psychological-*

She likes to cleanliness, washing, and fear of contamination of germs. She shows a very anxious behaviour.

- *Social-*

Patient's role was as a house maker meant her job was to clean didn't have work to distract her from cleaning. She has no support of her family as she her stop saying anything to her.

XIV. PRECIPITATING FACTOR

- *Biological-*

She was having good health not having other complications in treatment.

- *Psychological-*

She possesses good judgement. She is aware of her problem and recognizes need for change.

- *Social-*

She feels irritated she shout on the people. She doesn't talk to neighbour, relatives. This is because she spends all her time in activities.

XV. PERPETUATING FACTOR:

- *Biological*

She may have the OCD symptoms as genetically by her father.

- *Psychological*

The beliefs of cleaning, washing increase the anxiety. the probability that the individual will engage in these activities when a contamination fear occur in the future is increased.

- *Social*

Behaviour toward her is frustrating by her family because always in a irritating mood.

XVI. TREATMENT HISTORY

She took treatment from many faith healer, psychiatrist and homeopathic doctors. But no recovery was found. She took medicine by clinical psychiatrist, after 5 month she left the medicine because of the weight gain and drowsy.

XVII. DETAILED ABOUT PLANED OR UNWANTED CHILD

Her father and her grandmother was not showing any affection toward her. After delivery father did not come in hospital to see her because she was a girl child and he was expecting a boy child. Father and her grandmother did not talk to her.

XVIII. MENTAL STATUS EXAM

XYY was having fair complex women who appeared her stated age. She was well groomed herself. She is having difficulty sitting on the chair. Her speech was rapid, she rarely finished a sentences. She was conscious about day, month .She described her mood as anxious her affected appeared anxious. She was maintaining eye contact. She has level of cleanliness is overtly clean. she has cuts near nails due to cleaning. She has ill health, helplessness, death wish as thoughts alienation. She was having good concentration. She was having difficulty in attention. She was having lack of insight.

XIX. MANAGEMENT AND OUTCOME

Patient took treatment from many faith healers, psychiatric and homeopathic doctors but no recovery was found. At the time when she start taking treatment patients got side effects of medicines and for the most of the day she feels drowsy due to sleep she show less activities. But after that she left the treatment she take medicine for 5 month. After that she was not motivated about to take care of her illness. No one response, her activity because most of the time shows irritable behaviour. By this, the outcome from this case, presently she has left on her conditions. She has increase the time of spending much time for washing, cleaning utensils, house bathing duration. She separated her bathroom, room, chairs. so that no one can touch her things. she has fear to get contaminated by dirt.

XX. DISCUSSION AND CONCLUSION

Present case was a example of OCD However, the symptoms of disorder like washing, bathing, cleaning herself. Rather, it started when she went to fort after that day by day symptoms get increase. The clinical appraisal and therapeutic talk uncovered that seriousness of OCD was definitely encouraged by relational correspondence and communicated feelings. In this way there was a reasonable implication for anticipation her significant other ought to have been mindful and watchful about her exercises and in addition attentive on effect of relational managing on the patient passionate emotions and perception as all these influenced her mental working seriously in everyday life. Two extra focuses worth specify here ; consciousness of the sickness, treatment impact in OCD for which quiet was not a desire as she had a place with India. Eventually, She is not getting any motivation for taking treatment and her husband left her on her way. Treatment like "behavioural therapy" and "Cognitive Behavioural therapy" is typically an utilization of this approach is in the treatment of Compulsive practices in OCD . The patient should presented to circumstances that arouse tension and make an upsurge to take part in the target compulsive behaviour such as contamination fears, washing. However, repeated session of this therapy can lead to a improvement less strong compulsive urges.

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