

Case Report

Obsessive-Compulsive Disorder in Adolescence

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SUMMARY

Obsessive-compulsive disorder (OCD) isn't commonly observed during adolescence as compared to the adulthood. Especially mostly in countries like India and other developing societies, where awareness, orientation to mental health and its psychological treatment are undergoing 'infancy or adolescence' for several reasons, the neurotic disorders of children and adolescents (e.g., anxiety disorders) are rarely reported to mental health clinicians. Rather, psychotic disorders are even registered quite delayed in hospitals and private clinics. In such scenario, referral and clinical consultation for treatment of the obsessive-compulsive disorder in adolescence is indeed uncommon. The present study is a case report of a 17-year old adolescent male with obsessive-compulsive disorder. The case was registered in a general medical clinic and referred to the author for further psychological assessment and intervention. He was comprehensively examined through clinical interview, Y-BOCS and treated by cognitive-behavior technique of intervention without the inclusion of psychiatric treatment. Details of the psychological assessment and intervention have been presented in this case report. ■

KEYWORDS Obsessive-compulsive disorder; Clinical interview; Mental status examination; Cognitive-behavior therapy

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Obsessive-compulsive disorder (OCD) is characterized by recurrent, unwanted, distressing thoughts and resulted compulsive behavior. The obsessions are defined as persistent, senseless and intrusive thoughts, images, doubts, impulses, fears. Similarly, the compulsions are repetitive acts which compel a person to perform in a response to a given obsessive thought (1). In fact, persons with OCD realize that their distressing and disturbing thoughts and behaviors are unwelcome and consume large amounts of time interfering with their abilities to psycho-socio-occupational functioning. An interesting fact is that usually people with this disorder recognize that their obsessions and compulsions are irrational but themselves find helpless and incapable to suppress them. Often this disorder begins in adolescence or early adulthood, however, usually it is not recognized as a clinical problem in adolescence and thus clinical reporting and intervention is knowingly delayed sometimes due to stigma, but at times unknowingly also. Women are slightly more affected by OCD as compared to men. In case of minors, one in two hundred children is affected by OCD in the USA (2). Recently a comprehensive investigation on OCD has been conducted in India (3). A similar research conducted in the previous decade observed that male children outnumbered in OCD with comparison to female children comprising major obsessive features of contamination (62%), sex (22%), religion (22%), hoarding (7%), and compulsive features of washing/ cleaning (69%), repeating (62%), checking (47%) & counting (15%) (4). This disorder can also be affected by the socio-cultural factors in a given society (5).

The purpose of the present case study is twofold. At one hand, the author aimed at to present an adolescent client (usually not reported) who was referred to a qualified clinical psychologist for relevant intervention, and on the other hand, to establish and spread knowledge and information about psychological intervention in treating such psychological disorder where psychiatric services are scanty, irregular and inapproachable for semi-urban/rural people.

CASE IDENTIFICATION

DM (changed name) was a 17-year old male who was living in a small town of Katihar in Bihar, India. He was the second child and completing grade ten, among four including two brothers and two sisters. He belonged to

an orthodox Hindu family of middle socio-economic status. His father was a government servant and mother was running a provision store. His brother was occupied in mother's business and sisters were in school. In nutshell, he belonged to a well-knitted family with good interpersonal terms. He achieved all developmental milestones at appropriate age level.

HISTORY OF PRESENT ILLNESS

The problem began when DM started realizing that something had been happening different and unusual nearly for four years with him. He started kicking stones while walking on the road and became used to. Even he came back to kick stones which he missed and passed over without hitting and it was happening in the presence of friends also. Thereafter, he started spitting in equal number on his left and right sides while walking and kicking stones. Gradually it became a part of his routine; however, he felt internally bad, uncomfortable and at unease when attempted to leave these activities. He failed to abandon these behaviors especially while going to school as sometimes he got late and punished by the teachers. The problem slowly became more serious and started generalizing in other acts and behaviors. Consequently, he started washing his hands and legs for equal number of times with increasing frequency, and cleaning different household utensils in the same fashion. One day, he noticed his problems seriously when he started moving his head from left to right and right to left in equal number during play activities. Gradually, it became known to many people including his family members and distressing for DM. All these activities were interfering with his daily activities including studies and familial responsibilities. As a result, he became a mediocre student in the school (while previously he was a good student) as well as a poor player in football as it shook his confidence and ruined daily life. His problems became more troublesome when he was scolded and criticized for mistakes assigned works and responsibilities. He was initially taken to a religious healer for treatment. The healer gave him some leaves as a medicine to sniff for curing the problem but it was not effective.

CLINICAL AND PSYCHOLOGICAL ASSESSMENT

His clinical assessment including clinical interview and mental status examination diagnosed him a person with OCD as per the diagnostic guidelines of DSM-IV (6). During the assessment, he was cooperative, oriented and insightful. His obsessive thoughts and compulsive behaviors were conspicuously recognized. He was little bit depressed and having some sleep disturbance which appeared secondary to the psychopathology. No thought-, psycho-motor and other psychological disorders were found. The complexity of the symptomatic profile was moderate to severe on the Yale-Brown Obsessive-Compulsive Scale (Y-BOCS). However, the possible psychological dynamics of the problem revealed that the severity of the client's problem was often catalyzed by criticisms, reprimand and negative comments of family members, teachers and friends. It made him self-centered and ruminating in difficult situations. To distract, divert and relieve himself from these remarks, he occupied himself in such activities to displace his anger and comfort which developed psychopathological and compulsive behaviors in course of time. Nonetheless, he had a good insight into the problem as per his cognitive development, social support system and prognosis. Treatment history disclosed that DM was under psychiatric treatment but since his treating physician became suddenly out of station without prior information, so he discontinued after one week of intervention and missed the treatment details. He consulted for psychological intervention nearly after 3-month of gap since psychiatric treatment.

PSYCHOLOGICAL INTERVENTION

The client and his caretakers were properly informed about the diagnosis and nature of desirable treatment in OCD. He was taken for psychological intervention by the cognitive-behavior therapy with the consent of the client and his family. The mutually decided treatment planning and proceedings comprised exposure and response prevention, thought stopping, activity scheduling, cognitive restructuring and brief group counseling including family and friends (7). The client was called twice a week at the fixed time for treatment with parents.

During the first session of the psychological treatment, twenty one situations were fabricated for exposure therapy and response prevention through systematic desensitization at the clinic and home as well. All sit-

uations were arranged on a hierarchy by consent of DM with ascending anxiety level on the Subjective Units of Distress Scale (SUDS). During the subsequent sessions, the client was taught and trained on relaxation technique to learn how to be relaxed and paused in anxiety-causing situations due to the features of the OCD. And, he was kept relaxed in all sessions prior to exposure followed by response prevention. Out of twenty one situations, only three situations were taken for exposure and response prevention in each session of treatment. In the technique of exposure and response prevention, the client repeatedly confronts the fearsome situation while tolerating the anxiety and simultaneously refraining the compulsive behavior as a test of whether the feared consequences occur, and cope with the situation and anxiety both. Such exposure can be gradual (e.g., systematic desensitization) or in flooding and implosion (e.g., in vivo and in vitro exposure). In relation to the present case, this technique was implemented on both behavioral and cognitive level until the anxiety of the client came down to zero on SUDS in each of hierarchical situations. After, initial success of exposure and response prevention, intervention through flooding and implosion were also incorporated comprising his real life situations, e.g., kicking stones for equal number of times on the road, spitting at left and right sides in equal number, moving neck towards in left and right directions equally etc. After every session of treatment, the client was assigned with some similar home work assignments (i.e., activity scheduling) to practice similar exposure in real life situations. As a total, DM took eleven sessions in exposure and response prevention for complete relief from the symptoms of OCD. In addition, thought stopping was also implemented which helped DM a lot to control his obsessive thoughts. In this technique, the client is taught to interrupt the flow of obsessive thoughts to deal more effectively with both of the thoughts and situations. In the beginning, the flow of obsessive thoughts is induced by the therapist and is interrupted with a sudden stimulus, e.g., saying 'stop it' loudly while slapping the desk by the clinician. It is repeated for ten minutes. Hereafter, the situation of thought inducing is continued but it is interrupted by the client him/herself with the repetition for another ten minutes. Thereafter, the process of interruption by the client is continued but it is done silently in place of loud and emphatic interruption. DM was very much benefited by this technique as it facilitated his recuperation from severe distress of obsession. Furthermore, the

gradual success with the thought stopping, and exposure and response prevention were followed by cognitive restructuring which focused on helping the client to learn to take time and look critically at the obsessive thoughts, feeling and compulsive behaviors generated in various situations, and reduce client's tendency to jump automatically to misinterpretation and conclusion of relationship between obsession and compulsion. It makes explicit use of cognitive concepts to understand and modify overt behavior helping the client in gradually replacing negative self-verbalizations with the positive statements. It facilitates more logical and effective problem-solving to the existing problems and reduces the probability of similar problems occurring in the future. Thus, it contributes significantly in increasing self-efficacy which comprises self-control, self-monitoring, self-reward and self-evaluation as well. This technique helped DM in quick recovery in forthcoming sessions and effective compensation of social, educational and occupational outcomes. Later, few sessions were focused on family and group interventions as indicated in DM's case. Since his problem was also facilitated by the comments and reprimands of family, teachers and friends, therefore, significant persons from these areas were benignly called and included in his intervention program. They were taught about the nature of the problem, its severity affecting psycho-social functioning and their role in treatment. They were confirmed that the purpose of their scolds and criticisms was not against of DM, but since he was caught by a clinical problem and related negative cognitive and emotional development, therefore, he was unable to interpret their comments positively, rather misconstrued the same which snowballed his symptoms of OCD. They were advised to reinforce his positive outcomes in course of the treatment DM's recovery and psycho-social efficiency. At last, DM recovered from all symptoms of OCD and associated depression and sleep disturbances in sixteen sessions of psychological intervention.

The present case was a typical example of OCD. However, the symptoms of disorder originated atypically, i.e., without any obvious/common antecedent incident/life event/s. Rather, it started distinctively with natural playing activities (common in India) of childhood, insightfully recognized by the client at minor age, and its dependence on psychological intervention. The clinical assessment and therapeutic discussions revealed that severity of OCD was inevitably facilitated by interpersonal communication and expressed emotions (8, 9). Thus, there was a clear implication for prevention that parents should have been attentive and careful about even normal activities of DM, as well as, observant on impact of interpersonal dealings on the clients' emotional feelings and cognition as all these affected his psychosocial functioning badly in daily life. Two additional points worth mention here: impact of socio-economic status & treatment of OCD and recovery without psychiatric treatment in this case. It is well-reported that socio-economic status duly affects clinical status and treatment effectiveness in OCD (10, 11), for which DM was not an exception as he belonged to a poor state of India. But it is appropriate to highlight that despite being referred from a distant place for treatment, his dependence of psychologist, consistent and adequate compliance to psychological treatment along with ongoing desirable results made his intervention cost-effective (by reducing number of sessions and payment) facilitating quick recovery. In fact, a sudden absence of DM's treating psychiatrist became blessing in disguise for him in psychological treatment from both financial and therapeutic viewpoints. It was closely observed that a kind of hard work on the part of clinician on psycho-education to and therapeutic relationships at inception with DM (as he was an adolescent) and his immediate care takers won their confidence and contributed a lot in entire interventional exercises, recovery and in providing guidelines for future prevention. Eventually, DM was fully cured by psychological treatment without psychiatric medication.■

DISCUSSION AND CONCLUSION

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