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Case Report on: Obsessive – Compulsive Disorder Presenting Precipitating Factor.

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ABSTRACT:

Introduction: Obsessive compulsive disorder is a mental illness in which a person has persistent unwanted thoughts, such as phrases or ideas that they believe to be inappropriate or absurd. An obsessional impulse or concept altered people's personalities. In India, the lifetime prevalence of OCD is between two and three percent, which translates to two to three cases of the condition per hundred persons.

Patient history : A 23 years young female visited to AVBRH psychtric OPD Hospital by her father, According to her father chief complaints of Decrease social interaction ,Decreases sleep (insomnia) ,Withdrawal behavior ,Loss of appetite, Irritability since 6 months, Abnormal Behavior , excessive salivation ,Suspiciousness with aunty, Fearfulness , Repeated hand washing(20 to 25 times in a day) since 2months ,Take bath up to 1 to 2 hrs. Since 2 months. Stereotype movement with hands with voluntary since 4 months.

Clinical findings: The investigation carried out such as history taken,- Precipitating factor present physical examination, and mental status examination revealed that speech, mood, effect , content of thought and judgment was found impaired.

Management and prognosis: Patient treated with tab clozapine 0.5 mg OD ,Tab Olanzipine 5mg OD . Thought stopping technique, relaxation therapies- deep breathing technique, yoga and music therapy has been thought to client, also did counseling of client. After one week improved the sleeping pattern of client and minimize the obsessive behavior (minimize the duration of hand washing (it is 7 to 8 times in a day and taking bath half an hours.

Keywords: obsessive compulsive disorder, mental health,

Introduction: obsessive –

compulsive disorder is a mental disorder that is characterized by unwanted thoughts or obsession. It may cause compulsions, the need to repeat an action. Some people struggle with both compulsions and obsessions.[1] it is the chronic condition in which the symptoms are come and go over long time. The experience of obsessions and compulsions seen in patient at a some point. Some time it is very common in people for example to check the door lock, to check stove or gas.[2] OCD affects 2% of people nationwide. The symptoms often first arise in childhood or adolescence, and they very seldom do so after the age of 40. OCD is one of many anxiety disorders that involve obsessive thoughts and compulsive behaviors. A typical symptom of OCD is the presence of intrusive thoughts, visions, or desires that the sufferer feels powerless to suppress.[3] OCD sufferers might hesitate to seek help because of feelings of embarrassment or shame. There is no reason to be ashamed or embarrassed about having OCD because it is a health disease like any other. You're not "mad" if you have OCD, and it's not your fault if you do.[4] Some children have thoughts like bother them, and they feel like they have to do something about those thoughts, despite the fact that their behaviours are illogical. For instance, if they don't wear a favourite item of clothing, they can be concerned about ill luck. Even when they try to suppress them or dismiss them, some children's thoughts and inclinations to act in a certain way continue.[5]

There are many risk factor which cause the obsessive compulsive disorder like Stressful life situations, such a vehicle accident or the death of a loved one, have been known to set off the OCD symptoms of intrusive thoughts, emotional discomfort, and other symptoms in patients.

The patient may also be at risk of developing OCD if they also have other mental illnesses including depression, anxiety, or a tic disorder (like Tourette syndrome). Tourette syndrome may also be diagnosed in specific situations where the patient has a preoccupation with yelling profane phrases or acting.[6]

Case History:

A 23yers old female was presented to AVBRH Psychiatric OPD by her father and brother. She belongs to middle class family. She passed her 12th. After 12th she left her education due to low socioeconomic status. According to her father say that, “her aunty dispute her for using washroom and their

cleanliness whenever we are going to our farm" After that her family member observe that decrease social interaction, withdrawal behaviour, irritability, sleep disturbances, loss of appetite, occasional episodes of abnormal behaviour, suspiciousness about her aunty , fearfulness for germs on hands, since 6 months, stereotype movements with hands which voluntary since 4 months, repeated hand washing from 2 months, the patient has also be taking 1 to 2hrs to take a bath.

Chief Complaints:

According to Patient: - she said that "mala maze aai baba gheun ale, mala kahihi zalela nahi"

According to patient's relative (Father and Mother)

- Decrease social interaction with everyone since 6 months
- Decreases sleep (insomnia) since 6 months
- Withdrawal behaviour since 6 months
- Loss of appetite since since 6 months
- Abnormal Behaviour since 2 months
- Irritability since 6 months
- Suspiciousness with aunty(she said that, her aunty want to her family since 4 months)
- Fearfulness since 4 months
- Gesturing behaviour since 4 months
- Repeated hand washing(she said that, 'I feel that germs on my hand') since 2months
- Take bath up-to 1 to 2 hrs.
- Socio occupational impairment.

PRESENT PSYCHIATRIC HISTORY

- Onset - Insidious.
- Duration - 6 months.
- Course - Continuous
- Intensity - gradually progressive

PRECIPITATING FACTORS: Family Dispute (patient developing delusional thinking towards her aunty.)

Relevant Past Intervention and Outcome: Before 4 months ago, she came with her father to Psychiatric OPD with the complaint of Suspiciousness, irritability, repetitive hand washing, excessive salivation, fearfulness, gesturing behaviour, decrease social interaction. Tab. Olazelpam 5mg Hs, given to patient and after that patient came for follow-up call patient for follow up. She was taking medication continuously but her symptoms not minimized.

PAST MEDICAL HISTORY: patient was admitted in Hospital at Wani before 4 years ago for Maleana. She was fine after 5 days. (No documentation with her relatives)

FAMILY HISTORY: She belongs to a nuclear family. She lives with her father, mother and one brother in their own house. Her father is a farmer.

PREMORBID PERSONALITY: Her personality was optimistic; she was cheerful person, and helping nature towards others. She always put her family first in everything. She was kind and gentle towards people. She was confident in what she does.

Moral and religious beliefs: - she belongs to Hindu religion and follows its culture and custom.

Fantasy life: - she did not believe in fantasy life.

Habit: - She worked in her father's farm during free time in school.

Interpersonal relationship with family, friend: - Socially well adjusted.

Iintrovert/Eextrovert: - Extrovert.

Use of leisure time: - she spent her leisure time to watching T.V.

Mental Status Examination: In mental status examination it was found that the patient's speech, mood, affect, content of thoughts and judgment was found to affected and impaired.

General observations:

Disturbed sleeping pattern is present. Inadequate food intake is present.

Treatment and Outcome: Here the patient treated with tab Clozapine 0.5 mg OD, Tab. Olazapine 5mg OD, Thought stopping technique, relaxation therapies – deep breathing technique, yoga and music therapy has been thought to client, also did counselling of client. After one week improved the sleeping pattern of client & minimize the obsessive behavior (minimize the duration of hand washing (it is 7 to 8 times in a day and taking bath half an hour)

Discussion

This study is shortly different as a patient shows various complications and the chief character are find out of obsessive-compulsive behaviour with anxiety and stress. The symptoms are decreasing social interaction, withdrawal behavior, irritability, sleep disturbances, loss of appetite, occasional episodes of abnormal behavior, suspiciousness about her aunty, fearfulness for germs on her hands, since 6 months, stereotype movements with hands which voluntary since 4 months, repeated hand washing from 2 months, the patient has also been taking 1 to 2 hrs bath.[7] Also, the other symptom patient feels excessive salivation and her mother told she was doing hand washing more than 20 times. She had no family history of mental illness. But the causative factor is poor socioeconomic status. The precipitating factor is her family dispute with her aunty dispute with her for using the washroom and their cleanliness whenever her parents go to their farm. The patient is trying to avoid social gatherings and communicate the other people. In the Interview section, patient told that, her no history of OCD or any psychotic condition and she had no special medical/psychiatric history.[8] after being admitted to the hospital she was diagnosed with OCD and then as soon as she was done investigation and take proper treatment started. She showing great improvement and the treatment still going until the last date of care.[9]

One article report by Vikas Menon on, "Juvenile obsessive-compulsive disorder. The aim of the report to assess the juvenile condition and assess severity. It is one the most disabling and potentially chronic level anxiety disorder. Condition of images as a symptom occur less frequently than other type of obsession. In that report, the author describe a 12 years boy admitted in hospital with chief complaint are intrusive behavior, repetitive behavior In that study, obsessional images were the predominant symptoms.[10]

A family study presented on OCD the study shows that prevalence of OCD in lifetime, In that OCD was significantly higher in case compared with control relatives. OCD high rates in case relatives. No patient of OCD clinical manifestation was detected in the relatives of probands whose age at onset of symptoms was 18 years or older. Obsessive – compulsive personality with probands or tics were not more likely to have relatives with OCD. The disorder obsessive-compulsive disorder runs in families. Compulsions are more general to the phenotypic than obsessions are. Age of OCD start is important for identifying a familial subtype.[11]

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