WWW.IJRPR.COM

International Journal of Research Publication and Reviews

Journal homepage: www.ijrpr.com ISSN 2582-7421

Depression with Stammering with OCD; A Case Report

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ABSTRACT

Background: Mental and behavioral diseases affect approximately 450 million people globally. Depression will overtake hyperglycemia as the second leading cause of global illness burden in the next 20 years. Regression to the premedical anal sadistic phase, together with the employment of specific ego protective factors such as isolation, undoing, displacement, and reaction formation, may lead to OCD, as according Freud.

Patient history: A 20year old male was admitted in AVBRH hospital (acharya vinoba bhave rural hospital) on a date 24/01/2022 in psychiatric ward with chief complete of When I think of contamination, two things come to mind: contamination and filth. He has doubts about his brother's ability to sell estate and has a difficult time dealing with uncertainty. He also needs things orderly and symmetrical. Sleep disturbance, extreme emotional distress, stammering medication or drugs. patient illness duration is 4 months onset.

Clinical findings: The patient was subjected to variety of test, including a A physical exam, a mental status assessment, a neurological examination, and a blood sample are all conducted. Test and a urine test.

Medical Management: hospitalized patient and give antidepressants medicine and antipsychotic drugs, give cognitive behavioral therapy nutritional pattern maintain. iv fluid maintain and monitor the patient 4 houraly maintained nursing care plan and TPR chart. also input and output chart maintained.

Nursing management: Administered fluid replacement, maintain the input and output chart. vital sign checked and recorded, nutritional pattern maintained.

Conclusion: A physical exam, a mental status assessment, a neurological examination, and a blood sample are all conducted. judge and feels and behaviors. Often interferes with a person's ability to significantly interfere with functioning in daily life.

Key Word: depression and ocd disorder stammering is described in ICD-10 .

INTRODUCTION:

About 10% of the adult population suffers severe mental issues at some point in their lives. Around 20% of the patients seen by primary health care providers suffer from one or more mental illnesses. Many epidemiological studies have been undertaken in India over the last two decades; Mental disorders impact 18 to 207 people per 1000 people, with a median of 65.4 people per 1000 at any one time. Reaction formation is a symptom of OCD. 2.07 percent of the population suffers from severe mental illness or epilepsy. Mental disorder is diagnosed in a high percentage of adult patients (10.4 percent to 53.0 cent) that visit the general outpatient department.[1]

OCD can significantly harm interpersonal relationships. Recreational interests, the quality of your education or job, and your sense of happiness are all things to consider. According to study, Major depressive episodes, which include continuous sorrow for a few days or more, social withdrawal, and other signs, are experienced by 25 to 50 percent of OCD patients. having issues with your eating, sleep, sex drive, and having increased emotions, feeling hopeless, and unfit for consumption.[2]

Major depressive episodes, which include continuous sorrow for a few days or more, social withdrawal, and other signs, are reported by 25 to 50 percent of OCD patients. having issues with your eating, sleep, sex drive, and having increased tears, feeling hopeless, and unfit for consumption.[3]

A complex disorder with a variety of symptoms, some of which are subtle and go unnoticed. Early recognition and diagnosis with therapy targeted to OCD may improve outcomes. Nonetheless, delay in diagnosis are typical. Various symptoms may occur in patients. Gains can emerge from treatment,

and some people may even experience remission. Millions around the world suffer from obsessive-compulsive disorder (OCD) a chronic illness. SSRI results are recommended as first-line therapy .[4]

Clinically, dementia and depression in elderly patients may look very alike. It's crucial to monitor the signs of depression since it's far easier to handle than dementia, which is what depressive .[5]

Although both men and women can feel depressed, the symptoms are often very different. Because depressed men frequently present, their loved ones, friends, and even doctors may not identify their rage or aggression as signs of depression despite the fact that they are furious or aggressive instead of sad. Men are also less likely than women to express, and seek treatment for mental illness. In spite of this, a lot of men struggle with depression..[6]

Patient information: A 20year old male was admitted in Rural hospital in psychiatric ward with chief complete of Fear of contamination or dirt. Suspiciousness towards brother for property selling and having difficulty tolerating uncertainty, stammering Irritability .patient illness duration is 4 months onset.

Clinical finding:

A patient has no previous medical history And there is no prior surgical history. Patient care to do fine.

Information specific to a patient:A 20 year male was admitted in rural hospital male psychiatric ward with chief complete of Sleep disturbances , Suspiciousness ,headaches , Fatigue, loss of appetite, loss of interest ,anxiety, restlessness, aggressive behavior, patient illness duration is 4 months onset .

Primary concerns of the client :A 20 yrs. Old male was admitted in rural hospital psychiatric OPD with chief complaint of Sleep disturbances , headaches , Fatigue, stammering, loss of appetite, loss of interest ,anxiety, restlessness, Suspiciousness, germ phobia and he doing repeatedly hand wash aggressive behavior, patient illness duration is 4 months onset .

family and psysocial history:

Patient was apparently asymptomatic 1 month ago when he struggling for sleep In 2019 patient was admitted in sewagramme with complaint of bizarre He was able to retain positive relationships with family,friends, doctors, nurses and other patients.

Clinical findings : 20 year old male living with parents patient was oriented to date, time, and place in the Present case, even though he was ill. He maintained to his personal hygiene. His blood pressure was normal. 130/80mm/hg, pulse rate is normal. And chief complaint of Sleep disturbances, headache, Fatigue, loss of appetite, loss of interest, anxiety, restlessness, aggressive behavior, patient illness duration is 3 months onset.

Diagnostic assessment:

The patient has no history of surgeries and other medical conditions. According to a physical examination, the patient has no history of depression. Dimensions 153 cm Weight 56 kg, Patient history Illness, past history and present history patients suffering for depression e disorder

Mood : inappropriate

Affect :pleasurable affect – not present

Unpleasurable affect – depression

Other affect anxiety ,fear

Attitude -co operative

Eye to eye contact – not maintained

Orientation: Patient oriented to place, time and person.

Intelligence : concrete intelligence is act but abstract intelligence May be confusion.

Judgement : the patient judgement and social is present .

I have done to mental status examination of the patient having problems that inappropriate grooming normal , rapports – maintain .

Eye to eye contact not

All investigation are done

After physical examination, and mental status examination, diagnostic procedure doctor diagnose a case of mixed anxiety depression disorder

Treatment : History collection is done ,Physical examination is done ,Mental status examination is done ,Secondary management : investigation is done

Pharmalogical treatment:

Cap. Flumode 20mg –OD

Tab. Olanzepine 10mg –HS

Tab . Clonazepam 0.5 mg –HS

Syp. Apptivate 2 tsp TDS

Providing antidepressants drugs

The most disabling aspect of depression should be treated first, by antidepressant medication

Nursing perspectives: vital signs are monitored. And cognitive behavioural therapy also given to the patient.

Discussion:

There has been debate over the nature of their relationship due to the frequency of co-morbidity and the large correlations between each measure Depression and Obsessive-Compulsive Disorder (OCD) are categorized as. Even so, there has been some debate over the nature of their relationship due to co-high morbidity's occurrence and the close correlations between each measure of it. OCD affects a large % of men, and some authors have claimed that it is actually a mood disease. The proposed that both disorders have their bases in negative affectivity. One view is that, while though depression is a necessary component of OCD, depression and OCD are 2 distinct disorders. This study's aim was to analyze a range of ideas in a non-clinical group and discover whether any factors were common to all of them. That is, these would all show up as markers of OCD and depression symptoms, hopelessness, and self-criticism. The Beck Hopelessness Scale, the Carroll Rating Scale, the Cognitions Checklist, Scale In other words, anxious and depressive ideation, hopelessness, and self-criticism would all show up as indications of OCD and depression symptoms. The Padua Inventory, Carroll Rating Scale, Cognitions Checklist, Self-Criticism Scale, and Beck Hopelessness, but a weaker connection between OCD and mood disorders. In path analyses, hostility, anxious and depressive cognitions, and both were predicted. OCD had higher beta-weights than any of the other disorders and had a higher beta value. Self-criticism only accurately predicted sadness, while pessimism failed to predict either issue but accurately predicted depressive thinking.[7]

Many patients with OCD still have residual symptoms despite getting a clinically relevant response (OCD). The primary goal of this study was to determine if adding behavior therapy to these patients' care would enhance their chances of success. The reach: Ninety-six DSM-IV OCD patients who responded to three months of medication treatment were given a random choice between receiving extra behavioral therapy or continuing their drug treatment alone for another six months. In addition to their drug treatment, patients who did not respond to drug therapy got cognitive behavioural therapy for six months. Samples were collected inbetweening October 1998 and June 2002. Patients with OCD who got behavioral therapy along with medications displayed greater improvement in their obsessive-Y-BOCS score change = +3.9 for completers), comin parison to those who continued receiving only therapy intervention. compulsive symptoms (change in Y-BOCS score) = 3.9 in the completers sample. Patients that received simply medication therapy phases on appearance, to be in remission more often. (For finishes, see page 0001). After six months, patients who got only behavioural therapy in addition to their medical therapy didn't even appear to be have improved of their obsessive-compulsive symptoms. However, the remission rate in this group was comparable to that in the group receiving only behavior therapy (Y-BOCS score change = 2.7 for completers). in addition. Immediately when a drug regimen has had a positive reaction The results show that patients who have responded to medication treatment can profit from adding cognitive behavior therapy. The data also suggest that the efficacy of cognitive behavioural therapy therapy increases when it is given directly afterward a pharmaceutical response.[8]

With 955 adult OCD patients, the Brazilian Research Consortium for Obsessive-Compulsive Spectrum Disorders conducted a cross-sectional study (C-TOC). Several clinical traits of adult OCD patients, either those with and those without co-morbid disorders were assessed using Fisher's exact test, t-tests, and Levin-lin U tests. attach tests Logistic regression analysis was also used after bivariate analyses of the co-morbidity of ADHD to determine the medical factors that were independently related with it. In patients with adult OCD, 13.7 percent of the population had ADHD at some point in their lives. People with OCD and ADHD showed more severe symptoms, according to recent studies. Higher prevalence of rheumatic fever and a faster onset of OCD symptoms. The neurological disorder Tourette syndrome is characterized by co-morbidity and a higher This relationship was the four-year follow-up. The prospective relation between OCD and depression decreases and secure attachment type. OCD sufferers might develop depressive co morbidity as a result of the disorder's debilitating symptoms. Between the two-year and four-year follow-ups, 13.7 percent of the population had ADHD at some point in their lives. People with OCD and ADHD showed more severe symptoms, according to recent studies. higher prevalence of rheumatic fever.[9]

Obsessive-compulsive disorder & depression are companies (OCD). However, the mechanisms behind the depressed co morbidity in OCD are not well understood. We looked at the directionality and mediators of the link between OCD and depression in a large, OCD patients' prospective clinical sample. The information was collected from the 382 OCD patients who took part in the Netherlands Obsessive-Compulsive Disorder Study. The NOCDA study looks at the connections between two objects. The time connection between OCD and depressive symptoms was examined using pass structural equation techniques. There were follow-up assessments at the baseline, two, and 4 years. The possible relationship between OCD Using cognitive and interpersonal moderators, melancholy symptoms were Follow-up assessments were conducted at the baseline, two, and four-year points. The probable link between OCD and Melancholy symptoms were investigated using cognitive and interpersonal mediators. Cross-lagged research shows that OCD never

significantly predicts melancholy symptoms at a two-year follow-up. studied. Findings from a two-year follow-up indicate that OCD never significantly predicts depressive symptoms. The relationship had ended at the date of the four-year follow-up. The prospective link between secure attachment type reduced OCD and depression. Depressive co morbidity The disabling symptoms of OCD can have a functional impact on those who have it. Between the two-year and four-year follow-ups, OCD and depression symptoms both exhibited significant stabilizing effects, which would account for why there was not any correlation between them. Patients with OCD are protected from acquiring depressive symptoms in the future by secure attachment.[10]

CONCLUSION:

In the male psychiatric ward of a rural hospital, an use such man was admitted on a date with a chief complaint of sleep disturbances, suspiciousness, headaches, fatigue, loss of appetite, loss of interest, anxiety, restlessness, aggressive behavior, and phobia. The patient's illness started four months time of admission. After the physical examination and mental status examination and other tests finding the diagnosis are depression with stammering with obsessive compulsive disorder.

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