

In-patient treatment for resistant obsessive-compulsive disorder

Mohammed A. Al-Sughayir, MBBS, KSU Psych.

ABSTRACT

Obsessive Compulsive Disorder is one of the increasing psychological disorders. If not detected early and treated properly, obsessive-compulsive disorder usually becomes an incapacitating illness adversely affecting almost all aspects of the patient's life. Outpatient behavioral and pharmacotherapies frequently fail. This is a report on a severe case of obsessive-compulsive disorder that was treated as an in-patient with both behavior and pharmacotherapies, she was then followed up for 5 years with no relapse. The case reflects the importance and the need for in-patient units for severe resistant obsessive compulsive cases especially in Saudi Arabia where we have an increasing number of such cases.

Keywords: Obsessive compulsive-disorder, In-patient behavior therapy.

Saudi Medical Journal 2000; Vol. 21 (2): 193-195

Obsessive Compulsive Disorder (OCD) was previously thought to be relatively rare in the general population with a prevalence of 0.05%. Recent community studies have estimated a lifetime prevalence of 2.5%, and 1-year prevalence of 1.5%-2%.¹ The majority of individuals have a chronic waxing and waning course, with exacerbation of symptoms that may be related to stress. About 15% show progressive deterioration in occupational and social functioning. About 5% have an episodic course with minimal or no symptoms between episodes.² Studies on OCD in Arabic countries are unfortunately limited. In Egypt, Okasha found that the percentage of OCD in out patient psychiatric clinics was about 3%.³ Al-Kurafi found more religious rituals than any other obsessions among a group of OCD Kuwaiti patients. Mahgoub found the onset of OCD in Saudi Arabia patients was before the age of 30 years in 97% of subjects and religious themes were predominant.⁴ Al-Subaie et al reported a more acute onset and early help seeking in females than males in 45 cases of Saudi OCD patients.⁵

Currently, pharmacotherapy, combined with behavior therapy for patients with rituals, is considered a treatment of choice for OCD.⁶ However, most OCD patients in Saudi Arabia are treated with medication.⁵

This is a report on a case of OCD who failed to respond to out-patient pharmaco-behavioral treatment and was then treated with both medications and behavior therapy in the hospital and maintained lasting improvement for a 5 year follow up period.

Case Report. The patient was a 24 year-old single female college student. Her history dated to 3 years previously when she insidiously started to fear contamination from touching various things she considered dirty, for instance chick peas, ('Balila is the local name') soil, and anything that had been in any contact with these objects. In addition to that, she could not go anywhere that involved proximity to, or contact with, claimed dirty things especially chick peas. She had to use paper towels to touch

From the Department of Psychiatry, College of Medicine, King Saud University, Riyadh, Kingdom of Saudi Arabia.

Received 23rd August 1999. Accepted for publication in final form 25th October 1999.

Address correspondence and reprint request to: Dr. M. A. Al-Sughayir, Consultant Psychiatrist & Assistant Professor, College of Medicine, King Saud University, PO Box 21525, Riyadh 11485. Tel. +00966 (1) 4960203. Fax. +00966 (1) 4931525.

various 'dirty objects'. If however, she did happen to directly touch any dirty object, she experienced uncomfortable feelings, and she would engage in prolonged washing of her hands 30-50 times, her body sometimes, and would wash any clothing that had come into contact with the object. "These rituals are ridiculous, they keep up all my time and make life misery", she said. Rituals increasingly became handicapping, worse following the death of her father 2 years later. As a result of those symptoms her academic performance was adversely affected and her social life became restricted. The patient's family members were often driven to the verge of despair by the patient's behavior. Her mother pointed out that in the last year the rituals had gradually taken over the patient's life, she became depressed and at times would simply retire to bed and do nothing. The first contact with psychiatric services was 2 years after the onset of her OCD. She was seen in the outpatient psychiatric clinic and was tried on doses of Fluoxetine 40mg to 60mg per day for 7 weeks with minimal response to any of her washing rituals, though her depression improved to some extent. An outpatient behavior program was tried but she did not show any substantial improvement, most likely because of her short-lived resistance. In-patient behavior therapy was then considered along with pharmacotherapy. Fluoxetine was replaced with Clomipramine 50mg per day then gradually increased to 150mg. She tolerated the dose fairly well though she complained of sedation at times. A flooding program with chick peas, was designed cooperatively by the therapist and the nursing staff. The patient was fully informed about the program and encouraged to participate in the identification of appropriate goals for treatment. As she was showing apparent anxiety and tension prior to the first exposure-treatment session, Lorazepam 1mg p.o. and Propranolol 40mg p.o. were given to her 45 minutes before the session. She cooperated well with the exposure technique and response prevention. The technique involved exposing the patient to the contaminating object, chick peas, and subsequently preventing her from carrying out her usual cleaning rituals for 3 hours. A useful supplementary procedure was to model normal behavior by the therapist through touching chick peas repeatedly and requiring the patient to do the same. Daily exposure sessions were carried out during the first 2 weeks during which she made rapid progress, less tension, worries and compulsive washing. She then went home on leave several times for lengthening periods over week-ends to practice in her natural environment the self-treatment skills she was acquiring in the ward. Exposure homework included self-imposed exposure and response prevention with diary records of her progress.

Relatives (the mother and sister) were recruited as cotherapists and were taught to aid response

prevention by withholding reassurance and refusing to participate in rituals. As results were encouraging, she was asked to eat chick peas (Balila) which she did with little persuasion. She then ate chick peas repeatedly in the hospital without being resentful or disgusted. On discharge, after a 4 week in-patient stay, her compulsive rituals were 90% improved based on our clinical observation and patient's subjective report. Her hand washing related to fear of contamination was almost normal, she was able to take more responsibilities for her treatment and perform self-exposure, monitor and record her progress in diaries. Her overall tension was greatly reduced. The patients' improvement increased during further out-patient follow-up, support and encouragement.

She was maintained on Clomipramine 75mg at night for several weeks then reduced gradually to 25mg. Her self-esteem, self image and confidence increased substantially. She resumed her college studies, graduated and then got married. During the 5-year period of follow up (on an out-patient basis) she never had any relapses of OCD or severe depression. However, around the time of her marriage and her 2 deliveries she passed through minor depressive episodes with a few cleaning rituals, which were controlled by Clomipramine 50-75 mg a day. Although the patient was not totally cured by the treatment program, she was helped greatly to overcome the bulk of her handicap and develop a lasting strategy that helped her and her family to lead fairly normal lives despite residual problems and to detect and prevent potential relapses.

Discussion. Studies on OCD in Saudi Arabia are few. Our present case satisfied the DSM-IV criteria for obsessive-compulsive disorder as a primary diagnosis. Her depression seems secondary (rather than primary) to her obsessive rituals. This is supported by the course of illness and the relatively poor response to doses of Fluoxetine compared to the greatly sustained improvement in response to the de-conditioning behavioral program (exposure and response prevention).

Phenomenology of OCD, like its prevalence, was reported to be strikingly similar in various Western and non-Western cultures.⁷ Common comorbid psychiatric diagnoses in patients with OCD include depression, specific phobia and panic disorder. Obsessive patients in Saudi Arabia usually do not seek medical help until late in their suffering. Such a delay may continue for several years as these illnesses might not be recognized as medical problems and faith healers are usually consulted first for their treatment.⁵ Marks et al⁵ studied the effect of combining Clomipramine and exposure on obsessive-compulsive rituals. Clomipramine was found to have the greatest effect on mood, though it also significantly reduced rituals and improved social

adjustment. The Clomipramine effect was maximal from weeks 10 to 18, and it is possible that exposure might be better given during the latter period. Marks et al in Britain,⁹ Foa and Goldstein in the USA,¹⁰ and Boulougouris¹¹ in Greece, all found that exposure treatment shows greater improvement than the best reported in many other series which were treated by other means, including psychosurgery.

In spite of a good response to exposure and Clomipramine, our case had some transient depressive episodes (with some cleaning rituals) over the next 5 years. This accords with studies of Foa and Goldstein,¹⁰ and Meyer¹² who found that neither exposure treatment nor Clomipramine seem to affect the tendency for obsessives to continue to have occasional depressive episodes over the next 2 years. There have been many follow-up studies of patients suffering from obsessive-compulsive disorders (reviewed by Black 1974).¹³ Good lasting outcome was found to be related to compliance, presence of mood component and family support. On the other hand, patients' motivation for treatment, sex, age, age of onset and duration of obsessive-compulsive symptoms showed no significant correlations with outcome.¹⁴ Our case emphasizes the observation that once rituals have improved with exposure treatment, their full re-emergence is less likely during subsequent depressive periods.¹⁴ The mother's involvement in this case was crucial before progress could be made. Though the majority of OCD cases usually respond well to out-patient treatment, there are highly resistant complicated and chronic cases who need in-patient management. This case stresses the importance and illustrates the necessity of, in-patient behavior therapy for such resistant cases. Unfortunately most (if not all) the limited number of psychiatric in-patient units in Saudi Arabia are devoted to the acute mentally disturbed patients. Moreover these units are usually overloaded with such patients. That makes it more difficult to apply an in-patient behavior therapy for a neurotic patient.

The need for in-patient behavior therapy will be increasing, particularly with the increasing number of obsessive and phobic patients who fail to respond to pharmacotherapy on an out-patient basis. Demands for such treatment exceeds supply and in-patient units for behavior therapy in Saudi Arabia

could appreciably reduce patient's disability, family burden and major demands on health-care resources that are incurred by severe chronic OCD patients.

Acknowledgments. I would like to thank Dr. Rabie Hawari (Consultant Psychiatrist, King Khalid University Hospital) Consultant in charge of this case. Also Mrs. Zainab Jama deserves great thank for her secretarial assistance.

References

1. Stoll AL, Tohen M, Baldessarini RJ. Increasing frequency of the diagnosis of Obsessive Compulsive Disorders. *Am J Psychiatry* 1992; 149: 638-640
2. American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders. 4th ed. Washington, DC (USA): The American Psychiatric Association; 1994. p. 420.
3. Okasha A. Contemporary Psychiatry. Egypt: Anglo Bookstore; 1998.
4. Mahgoub O, Abdel-Hafeiz H. Pattern of Obsessive Compulsive disorder in Eastern Saudi Arabia. *Br J Psychiatry* 1991; 158: 480-482.
5. Al-Subaie A, Rahim F, Al-Hamad A. Obsessive Compulsive Disorder. *Annals of Saudi Medicine* 1992; 12 (6): 558-561.
6. Kaplan H, Sadock B. Anxiety Disorders. *Comprehensive Textbook of Psychiatry*. 6th ed. Baltimore (USA): Williams & Wilkins; Vol I p. 1225.
7. Goodwin D, Guze S, Robins E. Follow-up studies in Obsessive Neurosis. *Arch Gen Psychiatry* 1969; 20: 182-187.
8. Marks IM, Stern RS, Mawson D, Cobb J, McDonald R. Clomipramine and Exposure for Obsessive-compulsive Rituals: I. *British Journal of Psychiatry* 1980; 136: 1-25.
9. Marks IM, Hodgson R, Rarchman S. Treatment of chronic Obsessive-compulsive by in vivo exposure: A two year follow-up and issues in treatment. *Br J Psychiatry* 1975; 127: 239-264.
10. Foa EB, Goldstein A. Continuous Exposure and complete response prevention treatment of Obsessive-compulsive Neurosis. *Behaviour Therapy* 1980; 139: 127-134.
11. Boulougouris JC, Rabavilas A. The treatment of phobic and obsessive-compulsive disorders. UK: Oxford Pergamon; 1977. p. 212.
12. Meyer V, Lery R, Schnurer A. The Behavioural treatment of Obsessive-compulsive disorder. In: Beech H, editor. *Obsessional States*. London (UK): Methuen; 1974. p. 233-258.
13. Black A. The Natural History of Obsessional Neurosis. In: Beech H, editor. *Obsessional States*. London (UK): Methuen; 1974. p. 19-54.
14. Mawson D, Marks IM, Ramm E. Clomipramine and Exposure for chronic rituals: III. Two-year follow-up. *Br J Psychiatry* 1982; 140: 11-18.