Case Report

Obsessive Compulsive Disorder Refractory to Treatment: A Case Report

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ABSTRACT

Obsessive Compulsive Disorder (OCD) is known to present with recurrent, unwanted thoughts leading to anxiety and/or repetitive compulsive behaviors, which cause significant impairment in social and occupational functioning of an individual. There are both pharmacological and non-pharmacological treatment modalities for management of OC symptoms. However, treatment response in 40-60% of subjects is found to be unsatisfactory. This case report illustrates a patient's journey of OCD and discusses the challenges faced during its management.

Keywords: OCD, treatment-resistance, non-response to treatment, resistant OCD, refractory OCD

INTRODUCTION

Obsessive Compulsive Disorder is known to be a chronic psychiatric disorder that presents with recurrent and persistent thoughts, impulses or fears (obsessions), which are unwanted and create distress or anxiety in the patient (ego-dystonic). These may be accompanied by repetitive compulsive behaviors or mentations (compulsions) in order to alleviate the anxiety. These symptoms are known to cause significant impairment in a patient's socio-occupational functioning [(1)]. The lifetime prevalence of OCD in the general population is reported to be 2.3% [(2)]. Both pharmacological and behavioral treatment modalities have been implicated in alleviation of OC symptoms. However, controlled trials with SSRIs have demonstrated selective and limited efficacy in only 40-60% of patients, with about 30% of them failing to respond to conventional treatment [(3,4)]. Prevalence of treatment-resistant cases of OCD has been estimated to be around 30% (4). Non-response to an adequate treatment trial is associated with serious morbidity and disability[(5)]. This case report describes a patient's exhausting experience with OCD and the challenges faced by mental health professionals in managing her symptoms over the years.

CASE HISTORY

A 33 years old female presented to Psychiatry OPD with complaints of insomnia, restlessness, diminished interest in household work, low mood and crying spells. On further inquiry, she revealed that she feels intolerant of any dirt, dust or unhygienic surfaces in the house and hence, spends most of her time cleaning the house furniture, walls, kitchen-ware, footwear, washrooms and clothes. She engages in this activity for >8 hours a day, leaving no room for other chores or responsibilities and ends up feeling exhausted and irritated by day end. She seems to be well aware of her over-concern for cleanliness and admits that her repetitive thoughts pertaining to contamination are illogical and unwanted. While these unwanted thoughts create anxiety, she reports an immediate sense of relief once she has cleaned the surroundings or washed her hands. This relief however, is only short-lived and the thoughts recur soon after. In a day, she washes her hands with soap up to 20-30 times. Lately, she started expecting her family

members to follow her norms of cleanliness and wash their hands regularly (proxy-compulsions). If not complied with, she would become irritable and uncomfortable.

The patient is third born of three siblings, and belongs to middle socio-economic class, with family residing in urban area. She is an Arts graduate and prefers to be a homemaker. She is married since ten years, and has two children. However, there is no worsening of symptoms secondary to additional responsibility of their up-bringing.

She has been experiencing these symptoms for about ten years, with history of gradual onset and slow progression over time. The nature of symptoms has remained more or less similar, with intermittent past history of repetitive fears of contracting infections, or a general liking for symmetry and a predilection for lucky numbers. She takes keen interest in religious activities and prays daily in her set ritualistic fashion.

There is no history of episodic mood changes, fearfulness, suspicion, muttering or use of any psychoactive substance. History of any underlying organicity or medical or surgical illness was ruled out. There was no significant contributory family history. Her pre-morbid personality comprised of an inherent liking for neatness, orderliness, cleanliness and appropriateness of work. She was a shy and obedient child, who liked being punctual and perfect with her assignments. While her mother was strict and authoritarian in parenting style, her father was more permissive and supporting. However, she experienced no significant distress or dysfunction during her childhood and adolescence. She remembers starting to feel conscious of unclean items or surfaces in the house much after she got married and moved to a new home. As the years passed by, these thoughts persisted with fluctuating severity. There is no history of significant life events or stressor in recent past. However, inadequate response to treatment received so far along with the costs endured, added to her hopelessness and worry. Increasing burden of care in family members lead to expressed emotions, further worsening her symptoms.

TREATMENT HISTORY

When the patient presented to our OPD, she had been struggling with her illness for more than eight years. Over these years, she had resorted to help from a multitude of Psychiatrists and clinical Psychologists. She reported a history of adverse effects and/ or unsatisfactory response to previously prescribed medications. These trials included Fluoxetine (100 mg/day) followed independently by Clomipramine (150 mg/day). Another treatment record mentioned a trial of Fluvoxamine (150 mg/day), augmented with Risperidone (1 mg/day).

She reported some relief in obsessions (15-20%) with Fluoxetine alone, but was not satisfied with the response. With Clomipramine, she developed complaints of dry mouth, constipation and over-sedation during the day. While Fluvoxamine and Risperidone together helped marginally with reduction in symptom severity, the response was unsatisfactory. The latest trial received was of Sertraline (100 mg/day) for 3 months with no response whatsoever.

While medication compliance was an issue in the initial few years, it was ascertained that for the last 4-5 years, the patient had adhered to her treatment regimen, with the constant help of counselors and empathetic support from family members. No behavioral intervention directed towards OC symptom reduction had been introduced in the treatment plan so far.

After conducting routine blood investigations, a complete metabolic profile of the patient including thyroid profile was checked and found to be within normal limits. Imaging of the brain (MRI scan) showed no underlying organicity. Personality assessment and serial interviews were conducted to rule out differential diagnoses of other anxiety disorders, organic mental disorders (intrusive thoughts/ stereotypes), schizotypal personality (obsessive ruminations/ magical thinking), OC personality, psychosis (intrusive thoughts/ delusions), impulse control disorders and other OC spectrum disorders.

General and systemic examination of the patient was normal. Mental status examination showed diminished psychomotor activity, reduced tone, volume and pressure of speech, depressed affect, preoccupation with symptoms and intellectual insight into illness. Her score on YBOCS (Yale Brown Obsessive Compulsive Scale) indicated severe intensity of OC symptoms. And scoring on HAM-A (Hamilton Rating Scale for Anxiety) and HAM-D (Hamilton Rating Scale for Depression) showed moderate to severe anxiety and depression, respectively.

After thorough discussion it was concluded that this was a case of refractory OCD (failure in response to 3 successive trials of SSRIs for more than 12 weeks). A combined trial of Fluvoxamine (100 mg), Risperidone (2 mg) and low dose Clomipramine (75 mg) along with behavior therapy was introduced. Behavioral interventions included Psycho-education of the patient and her family members about OCD, its treatment response and prognosis, and sessions of Exposure and Response Prevention (ERP).

This regimen was implemented for the next 10-12 weeks, including up to 20-24 cumulative hours of ERP sessions. On the on-going treatment, the symptoms of low mood, insomnia, irritability and reduced interest in work subsided slowly. While the patient tolerated the above medications and developed better insight into her illness, she still complained of recurrent obsessions of contamination followed by yielding compulsions of hand-washing. The scores on HAM-A and HAM-D reduced considerably. Improvement in YBOCS score was $< 20\%$.

At this point, administration of Electroconvulsive Therapy (ECT) was considered. After explaining the need for ECT, addressing concerns about its safety and taking informed consent, six cycles of ECT were administered over two weeks duration. Unfortunately, there was no significant improvement observed in the symptoms. Another cycle of six ECTs was repeated, only to find marginal overall improvement.

The only mode of treatment left to be explored hereafter was invasive deep brain stimulation (DBS) and/or psychosurgery. However, owing to patient's unwillingness to undergo invasive procedures, this line of management was not pursued.

DISCUSSION

Refractory OCD has always been challenging in terms of definition, diagnosis, staging and management. Guy et al defined adequacy of trial, resistance and refractoriness to treatment [6]. Trial of at least 3 SSRIs in maximum doses for at least 12 weeks is defined as adequate [7,8]. The treatment must have included use of Clomipramine and/or Behavior Therapy (minimum 20 hours of ERP). Failure to respond to the above trials, i.e. (<25% reduction in YBOCS score) will be called as resistance to treatment.

The most common reasons for treatment resistance include presence of co-morbid disorders (organic mental illness, bipolar disorder, substance use disorder or personality disorders), inadequacy of management (dose and duration of medication trial), improper compliance to treatment (psychological resistance) and psycho-social issues [9].

Literature on management of OCD states that partial response to first-line pharmacotherapy (with SSRI) should be treated by augmentation or combination strategies or use of the molecule in tandem with behavioral interventions. Proposed augmentation strategies include use of Clonazepam (0.5-5mg/day), Buspirone (10-90 mg/day), Lithium (300-600 mg/day), Risperidone (2-4 mg/day), Aripiprazole (5-10 mg/day) or Olanzapine (up to 5mg/day). Alternatively, a combination of Clomipramine (75-150 mg/day) with SSRI is also proposed. Some novel/ experimental methods proposed but not studied are, use of MAOI (Monoamine-oxidase inhibitors) or intravenous Clomipramine. Use of Lamotrigine (titrated up to 150 mg/day) or Naltrexone (mg) in resistant OCD has also been reported [10, 11]. Anecdotal cases have documented response to treatment with Agomelatine augmentation (25 mg/day) on SSRI or intravenous infusion of Ketamine (0.5 mg/kg over 40 minutes) [12,13].

While traditional psychotherapy does not seem to have a promising role, use of behavioral interventions (ERP) and/ or cognitive strategies (to explore and modify underlying beliefs) has been advocated. There is a definite role of ECT in resistant OCD complicated by severe co-morbid Depression, suicidal ideation or socio-occupational incapacitation. Recent use of rTMS (repetitive trans-cranial magnetic stimulation) has been made for treating co-morbid symptoms of Depression in severe OCD. As last resort, stereotactic psycho-surgical intervention has also been proposed, once total adequacy and ineffectiveness of trials of pharmacological and psychological interventions has been ensured [9]. However, this is not a welcome treatment option due to its associated risks (frontal lobe dysfunction, personality changes, disinhibition, or poor executive functioning) and only a moderate level of reported efficacy (50-67%) of the procedure [14].

In our case, from the above recommended modalities of treating resistant OCD, most of the feasible options were included in the treatment plan. Serial clinical assessments of the case reiterated the resistant nature of the OC symptoms longitudinally. A multimodal treatment resulted in some improvement in the overall insight, secondary depression, social and occupational functioning and attitude of the patient towards her illness. We could also motivate the family members to accept the patient with her illness and provide consistent emotional support. As we could not alleviate her symptoms to a significant extent, we educated her to accept herself with this illness, learn to live with it and work on optimizing her lifestyle, in order to reduce routine disturbances associated with the symptoms.

CONCLUSION

This case report is to bring to notice of clinicians, academicians and researchers, the highly stubborn and resistant nature of OCD in some cases. It attempts to highlight the importance of practical considerations while managing OCD, such as: early screening at primary care level to watch for juvenile onset OC symptoms, maximizing the effectiveness of the first trial of pharmacotherapy with or without behavior therapy, bearing in mind the existence of underlying co-morbidities and differential diagnoses, addressing psychosocial issues and better utilization of non-pharmacological modalities; in order to provide holistic care, achieve maximum treatment response and minimize overall psychological distress in the patient.

CONFLICTS OF INTEREST

There are no conflicts of interest.

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