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Case Report

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A Psychodynamic Understanding of Obsessive Compulsive Disorder

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ABSTRACT
Obsessive Compulsive Disorder, (OCD) is characterized by obsession and/ or compulsion that lead to significant distress with functional impairment. Psychodynamic formulation is commonly used to understand the patient's unmet needs and could guide management plan. Psychodynamic psychotherapy is not the mainstay psychological treatment for OCD. Nevertheless, psychodynamic understandings are crucial to understanding the formulation of symptom. This case report illustrates a patient who is suffering from OCD which originated from his unresolved fixation in psychosexual anal stage, harsh superego, neurotic defense mechanisms of undoing and isolation of affect, and insecure attachment worsened during the COVID-19 pandemic. Psychodynamic issues should be explored for a more comprehensive psychosocial intervention, better therapeutic alliance and treatment outcome.

Keywords: Obsessive Compulsive Disorder, Psychodynamic Formulation, Psychosexual Anal Stage, Superego, Sexual Impulse, Undoing

Introduction

Obsessive Compulsive Disorder, OCD is a chronic, severe, incapacitating and profoundly disabling mental disorder that results in negative impacts on the patients' social, academic and occupational functioning. The estimated lifetime prevalence of OCD is 1 to 2.3% [1-3]. It is represented by the presence of obsessions and/or compulsions. An obsession is a recurrent and intrusive thought, urge, or image that is unwanted and causes marked anxiety or distress. A compulsion is a conscious repetitive behavior or mental act that an individual feels driven to perform in response to an obsession or according to rules that must be applied rigidly [4]. The commonest obsession is an obsession of contamination whereas the commonest compulsion is checking [3].

The combination of both pharmacological and non-pharmacological treatment is found to be more superior to medication alone [5,6]. Based on the Canadian Clinical Practice Guidelines 2014 and the National Institute for Health and Clinical Excellence (NICE) 2005, the mainstay of psychological treatment for obsessive compulsive disorder is cognitive behavioral therapy that includes exposure with response prevention that can bring about substantial improvement as supported by metaanalysis [7].

Etiology of obsessive compulsive disorder is multifactorial which includes bio psychosocial factors. Psychodynamic therapy is not a common psychological intervention for OCD. Nevertheless, having psychodynamic insight apart from understanding of cognitive behavioral model is crucial and helpful to understand the origin of illness in some OCD patients. Kempke and Luyten highlighted the increasing overlap of psychodynamic and cognitive behavioral models in patients with OCD. Their paper gave an overview of the growing convergence among psychodynamic and cognitive–behavioural approaches of this illness [8]. A careful psychosocial history and dynamic formulation are important to enrich understanding of patients with OCD that can thus guide the clinicians in a more comprehensive management plan.

Case Report

Mr. M was a 23-year-old, single, pre-university student who came to psychiatry clinic with complaints of recurrent thoughts that his body was dirty with repetitive washing for 7 months. This was his first psychiatry consultation. Mr. M presented with obsessions with the themes of contamination whereby he repetitively thought that his body, hands and feet were contaminated. He thought that his body was contaminated by

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his urine or seminal fluid, his hands were contaminated by the lizards or flies' droppings on the table or door knob and his feet were contaminated by faeces of his neighbor's dog. Mr. M also had recurrent doubts that he missed his steps in prayers and his prayers could be invalid. In order to neutralize his intense anxiety, he thus carried out rituals of washing and also repeating his prayers. His obsessions and compulsions were time consuming, that took up more than 8 hours a day. He experienced significant distress with social and academic functional impairment.

Following the commencement of Movement Control Order in March 2020 in Malaysia as a national policy to combat the COVID-19 pandemic, Mr. M experienced worsening of his obsessions and compulsions. He found stressful for being home bound and reduced social interactions. He began to experience depressive symptoms such as pervasive depressed mood, anhedonia, loss of appetite with significant weight loss, initial insomnia, psychomotor retardation, negative cognitions (worthlessness and hopelessness) with death wishes. There were no history of psychosis, manic or hypomanic symptom and other anxiety symptoms. He had no past head trauma or any neurological complaint. Mr. M did not have history of cigarette smoking, substance or alcohol use.

Mr. M could identify his stressor that occurred since around one and half year prior to the onset of his symptoms. He experienced pain at both his testicles and he was diagnosed to have mild hydrocele. Despite seeking for help from urologist and traditional healer, his condition persisted. His pain was aggravated whenever he had sexual arousal with penile erection. Mr. M perceived that his illness was critical. He thus changed his lifestyle by being more religious, taking healthy diet and stopped watching pornography. He attributed the cause of his condition as a result of his sinful sexual desire that led to punishment from God.

Mr. M had normal birth, growth and developmental history. He had no known medical illness. He is a heterosexual and he had one romantic relationship before. One of his siblings is suffering from anxiety disorder. Mr. M and his siblings were brought up by parents who practiced authoritarian parenting styles. They were expected to listen and obey their parents, score straight As in all examinations and strictly abide to rules and regulations. Failure of doing so would lead to physical punishment. Since young, Mr. M had high expectations of himself especially with his academic performance. He had self-criticism and he would self-blame, felt guilty and demotivated whenever he could not achieve his goals. Mr. M was a school prefect and an excellent student who did well in both his academic and extracurricular activities. He grew up as a perfectionist who always aimed for perfection and could hardly tolerate mistakes or imperfections. He was an introvert with high devotion to his studies. However, he did not have other features that were suggestive of anankastic/ obsessive compulsive personality disorder.

During Mr. M's psychiatric consultation, he was found to be anxious. He complained of low mood with obsessions following the themes of contamination, doubts and religion. No manifestation of psychosis or cognitive deficit was found. Mr. M had good insight regarding his conditions. His physical examinations were normal. Biopsychosocial investigations were carried out. His blood and urine investigations were normal. Yale-Brown Obsessive Compulsive Scale (Y-BOCS) was done and a moderate score of 22 was obtained (obsession=13, compulsion =9).

Mr. M was diagnosed to have Obsessive Compulsive Disorder, OCD, with good insight comorbid with Major Depressive Disorder, moderate, single episode. He was started on both pharmacological and non-pharmacological treatment following psychoeducation with shared decision making. Mr. M could not tolerate Escitalopram at 15mg daily as he experienced restlessness. He responded well to the subsequent medication, Fluoxetine 60 mg daily and Cognitive Behavioral Therapy (Exposure Prevention Therapy). Mr. M's scored 15 in YBOCS after 7 months of treatment, 32% reduction in score. His depressive symptoms were resolved. Mr. M had good adherence to his therapies and outpatient follow ups. He performed well in his final pre-university examination. He prepared to take up his degree course in public universities.

Discussion

Mr. M was genetically predisposed to psychiatric illness as there was family history of anxiety disorder in his sibling (first degree relative). The medical condition (hydrocele), social isolation following COVID-19 pandemic and major academic examinations could have precipitated and perpetuated his OCD with secondary depression. Learning theory such as operant conditioning by B. F. Skinner explained the positive reinforcement that would have perpetuated Mr. M's compulsions as by performing rituals, his anxiety could be reduced. However, after a deeper exploration of Mr. M's psychological factors, we found that a few psychodynamic concepts were prominent in this case.

Sigmund Freud postulated that unresolved fixation at the anal stage of development could bring about OCD in later life [9], where the impulses were in constant conflict with a rigid superego. Mr. M was brought up by very strict parents who practiced authoritarian parenting styles with high demand and low responsiveness. They set high standard and stern discipline. Mr. M's parents had very high expectations on his academic performance and would punish him if he failed to score straight As in his academic performance. Besides, they also instilled religious and moral values to their children since young. They were taught what was right and wrong and they were expected to follow rules and regulations strictly. Overly strict and harsh parenting such as in potty training may cause a child to be overly obsessed with orderliness and tidiness that are known as anal- retentive personalities predispose one that can to the development of OCD [9].

The harsh superego of Mr. M that serves as a self –critical conscience and constant reminder to the ego-ideal could perpetuate the conflict in his psyche. Superego is the representation of the rules, values, morals and taboos of society. Conscience or capacity for self-evaluation, criticism, and reproach will create guilt when social codes are violated. Mr. M had very strict upbringing, thus he internalised his parent's value to form a harsh superego. He was a perfectionist since young and was very critical to himself in terms of obeying rules. Failure of doing so, Mr. M would have self-criticism, self-blame, guilty and experience low mood. This was especially escalated

after he suffered from painful hydrocele which he attributed as a punishment of his sinful desire as the pain worsened during penile erection upon sexual arousal. Mr. M became more religious and he avoided any sexual desire. Mr. M's harsh superego was activated to control his impulsive id thus degraded his sexual desires and impulses as dirty or as a 'contaminant' that should be avoided. Therefore, Mr. M's developed compulsions as defences to mediate this conflict [10].

Mr. M had the neurotic ego defences of undoing and isolation of affect. Undoing is defined as attempting to negate sexual, aggressive or shameful implications from a previous comment or behaviour by elaborating, clarifying or doing the opposite [11]. Mr. MA perceived sinfulness of watching pornography triggered him to perceive his condition as a punishment from God thus transforming them to concerns of contamination with urine (that came out from his penis) or seminal fluid. He used undoing as a defense and attempted to negate his sexual impulses that he viewed as 'dirty' and 'sinful' mainly by performing the opposite, via washing and praying rituals [12]. He attempted to reduce his anxiety via undoing by performing his compulsions.

Mr. M also used isolation of affect as a defense mechanism that separates an idea from its associated affect state to avoid emotional turmoil [11]. Mr. M unconsciously isolated and disowned his undesirable thoughts that he viewed as sinful. Those thoughts were separated from the associated affect to safeguard him from anxiety-provoking sexual impulses.

Mr. M's insecure attachment with his parents complicates the situation. Both his parents were working and they practiced authoritarian parenting styles with high demand and low responsiveness. Secure attachment strongly influences the development of internal working models of relationships that are stored as mental schema and lead to experiences regarding the expectations of the behaviors of others toward the self. Literatures showed that the quality of attachment is crucial in tolerance of individuals, coping strategies of people with life challenges and maintaining mental health [13]. Attachment insecurities are risk factors for psychopathology such as anxiety or depression as seen in meta-analyses [14]. Dozier and Lee demonstrated that secure attachment style is inversely related to obsessive- compulsive disorders, and psychoticism [15]. Mr. M's insecure attachment to his parents had predisposed him to develop obsessive compulsive disorder and depression.

In current psychiatric practice, psychodynamic psychotherapy is not the main psychological treatment for OCD, but mental health practitioners should explore the possible underlying psychodynamic issues in order to plan for more comprehensive psychosocial intervention and approach. Perhaps, further studies and researches are needed to review the growing convergence among psychodynamic and cognitive behavioural models of OCD and the possibility of integration of both therapies. This can also improve the therapeutic and stimulate a positive mental health treatment outcome.

Ethical Statement

A written informed consent was obtained from the patient and his details were kept anonymous. This report had met the ethical guideline and legal requirements in Malaysia.

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Consent for Publication: A written informed consent was obtained from the patient.

Declaration of Competing Interest: There is no conflict of interest.

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