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Breaking Barriers in OCD Treatment: A Resistant Case Successfully Treated with an Innovative Exposure and Response Prevention Strategy

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ABSTRACT

It is widely recognized that the most effective approach to treating obsessive-compulsive disorder (OCD) combines medication with cognitive-behavioral therapy (CBT), particularly exposure and response prevention (ERP). This case sheds light on a unique and unconventional way of applying ERP in a patient with treatment-resistant and atypical OCD, ultimately proving more beneficial than medication alone. What made this case unusual was the patient's deeply ingrained overvalued ideas, superstitions, and strong religious beliefs, which played a significant role in shaping their symptoms. Additionally, the patient tended to misinterpret random events as meaningful, experienced heightened stimulus generalization, and responded best to in vivo exposure, making their treatment journey both challenging and distinct.

1. CASE REPORT

In the emergency room of a tertiary care hospital, a 28-year-old Hindu man from a remote, economically disadvantaged background arrived with persistent distressing thoughts. He was deeply troubled by a fear of contamination from ashes of a cremated body, which led to an intense aversion to dark-colored objects, excessive hand and foot washing, and prolonged, frequent bathing. During a comprehensive physical and psychological assessment upon admission, he shared a significant event from 1 year earlier—while attending a relative's funeral, ashes from the cremation had accidentally fallen on him and others. Since then, he had been struggling with overwhelming anxiety and compulsive cleansing rituals, unable to shake the feeling of being unclean. A few days later, the patient learned that two people who had attended the funeral with him had unexpectedly passed away. This deeply unsettled him, as he became convinced that the black ash from the cremation had caused their deaths—and that he, too, was at risk.

Overwhelmed by fear, he started associating the blackened wood used for cooking in his home with the funeral pyres, believing it carried the same ominous threat. In an attempt to rid himself of the perceived contamination, he obsessively cleaned his home, throwing out all the firewood. But no matter how much he scrubbed, his anxiety didn't subside. Desperate for relief, he resorted to taking multiple baths, hoping to cleanse himself of the unseen danger he feared. Cleaning and washing was taking around 2 hour in a whole day period. His frequency of washing and cleaning activities increased along with the severity of his anxiety over time. His sickness rendered him completely confined to his house and incapacitated. He also stopped other relatives from preventing any black things from coming into contact with members. He was causing and dealing with a lot of issues. A significant amount of stimulus generalization was associated with anything "black." Among other things, he began to get scared of black cows, dogs, birds, stones, clothing, and curtains.

After these results, he was given a diagnosis of obsessive compulsive disorder (OCD) and was started 50 mg of T. clomipramine along with T. fluvoxamine 50mg at night . T. clomipramine bwas then titrated to 150 mg as well T. fluvoxamine 300mg ; however, we were unable to raise the dosage after that since the patient began experiencing adverse symptoms. As adjuvants, low dose Tab. Aripirazole 2mg and Tab. Clonazepam 0.5mg BD were also introduced; however,

none of these medications produced much of an effect. After deciding to use cognitive behavioral therapy, we created a hierarchical list of every item that the patient was experiencing worry and distress over.

We asked him to visualize each item from his fear hierarchy while monitoring his vital signs and assessing his anxiety levels using the Hamilton Anxiety Rating Scale (HAM-A), either before or after the exercise.

Surprisingly, even the least distressing item on the list caused significant discomfort. His vital signs showed clear signs of distress, and his HAM-A score spiked to 24, confirming the intense anxiety he experienced—even at the lowest level of exposure.

Over the next few weeks, we gradually exposed him to black-colored charcoal, ash, and similar materials while closely monitoring his vital signs and anxiety levels using the HAM-A scale before and after each session. With time, he became more comfortable handling the ash, and his distress gradually decreased. However, as the impact of his condition took a toll on his daily life, relationships, and ability to work, he began to experience symptoms of depression. HAM-D was applied in which patient score a total of 21. The emotional burden eventually led to suicidal thoughts, prompting the introduction of Tab. Topiramate at 25 mg OD. As his treatment progressed, the dosage was increased to 200mg twice a day to better manage his symptoms. Since imaginal exposure had not led to significant improvement, we discussed the next steps with the patient and his family. With their informed consent, we decided to take him to a cremation site for in vivo exposure therapy.

However, upon arriving at the site, he was immediately overwhelmed with intense distress. The experience was so unsettling that he had to be taken back, and in response, he resorted to compulsive bathing—sometimes as many as 10 to 15 times a day. With ongoing supportive psychotherapy and reassurance, his excessive washing rituals gradually began to subside. Despite the initial setback, exposure therapy continued daily, helping him slowly build tolerance and reduce his anxiety over time.

The patient's progress was measured by how close he could get to the funeral pyres and how long he could stay at the cremation site. After three to four weeks of gradual exposure, he reached a significant milestone—he was able to hold the ashes from the pyres without distress and no longer felt the urge to bathe immediately afterward. His HAM-A and HAM-D scores reflected this improvement, as he could now visualize and confront his fears without experiencing overwhelming anxiety. Over time, his anxiety and depression lessened, and he gained confidence in facing his triggers. By the end of his 89-day hospital stay, he was prescribed 100 mg of T. clomipramine at bedtime, 100 mg of T. topiramate twice daily. He continued attending regular follow-up appointments, during which his medication dosage was carefully adjusted based on his progress.

After 1.5 years, the patient is doing well, consistently taking his medication, and remains completely free of symptoms. His anxiety no longer interferes with his daily life, and he has regained a sense of normalcy and confidence in himself.

2. DISCUSSION

The hallmark of obsessive-compulsive disorder (OCD) is the occurrence of recurring, persistent thoughts, pictures, or urges that significantly worsen anxiety or suffering. The individual endeavors to disregard or repress these through recurrent actions or thoughts in reaction (compulsions) [1]. OCD was identified by WHO as one of the ten most incapacitating illnesses due to the substantial influence it has on a person's life [2]. Common sets of obsessions and compulsions in patients with OCD include concerns about contamination together with washing or cleaning, concerns about harm to self or others together with checking, intrusive aggressive or sexual thoughts together with mental rituals, and concerns about symmetry together with ordering or counting. [3,4] OCD was initially believed to be quite rare. However, the first rigorous community surveys that used operational criteria for the diagnosis of mental disorders demonstrated that OCD was one of the most prevalent mental disorders[5], and OCD was estimated to make a considerable contribution to the global burden of disease[6]. A broad range of environmental factors, including adverse perinatal events such as birth complications, and stressful or traumatic events, have been identified as potential risk factors for OCD [7,8,9]. For those patients who insufficiently benefit from first-line SRI treatment and are characterized as having treatment-resistant OCD, practice guidelines offer clear guidance on next steps, including recommendations for a trial of a second SRI and then potentially a trial of clomipramine [10]. However, patients whose symptoms are not adequately improved by SRI treatment remain a significant clinical challenge.[11] If OCD patients are resistant to SRIs, evidence supports augmentation with atypical antipsychotics as a treatment [12,13]. This approach reflects the hypothesis that OCD is characterized by excessive striatal dopamine signaling, supported by multiple studies reporting reduced D2/D3 receptor binding in the striatum of OCD patients. [11,14] Notwithstanding the fact that there are other treatment approaches, pharmaceutical therapy in conjunction with cognitive behavior therapy (CBT)—exposure and response ERP prevention is regarded as first line [15]. Some OCD patients are shown to be resistant to therapy, even though the majority of cases respond to these first-line treatment modalities. Patients with OCD who see a ≥25 or 35% decrease in their Y-BOCS score after receiving sufficient first-line medications are considered treatment-resistant [16]. Despite selective serotonin reuptake inhibitors (SSRIs) and cognitive-behavioral therapy (CBT) being first-line treatments, approximately 30–40% of OCD patients do not respond adequately. Understanding the mechanisms behind treatment resistance is essential for improving therapeutic outcomes and identifying alternative approaches. [17] The study and

reporting of TR-OCD also contribute to the development of improved clinical guidelines and policy-making. Data collected from research informs organizations such as the American Psychiatric Association (APA) and the National Institute for Health and Care Excellence (NICE) to refine best practices for treating resistant cases. Additionally, this research can advocate for better insurance coverage and access to advanced treatment modalities for those suffering from severe, persistent OCD symptoms. [18,19] Studying and reporting TR-OCD is vital to advancing knowledge in psychiatry, refining treatment options, and ensuring that individuals with severe OCD receive the care they need. Increased research in this area will pave the way for more effective, personalized, and accessible treatment strategies that offer hope to those who continue to struggle with this debilitating condition. [20]

3. CONCLUSION

Psychiatrists continue to face significant challenges in treating cases of treatment-resistant OCD, as each patient presents with unique symptoms and underlying psychological patterns. Effective treatment requires a personalized approach that considers the individual's specific obsessions and compulsions, as well as their sociocultural background, which often plays a crucial role in shaping their condition. To provide the best possible care, treatment strategies must remain flexible and adaptable, evolving based on the patient's response and progress.

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