

Case report

Compulsive rituals by proxy

Dushad Ram, Arun Kumar

Abstract

The impact of obsessive compulsive disorder on family members is often overlooked. Family may take part in the performance of rituals to assist a relative with obsessive compulsive disorder. In this case report of compulsive ritual by proxy, a 35 year old

female substituted her husband to carry out her compulsive rituals.

Key words: compulsive rituals by proxy, obsessive compulsive disorder

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Introduction

Obsessive compulsive disorder (OCD) is a common psychiatric disorder, with a lifetime prevalence of 2-3 percent (1). Compulsion by-proxy in adults is a rare presentation of the obsessive compulsive phenomena. Here we present the case of a 35 year old female, who substituted her husband instead of her to perform compulsive behaviours.

Case report

A 35 year old married female patient, educated up to grade 7, with satisfactory pre-morbid functioning and a family history of obsessive compulsive disorder, presented to the psychiatric outpatient department (OPD) of a tertiary health care centre.

Twelve years ago, following the delivery of her second child, the patient had insidiously developed obsessions of dirt and contamination, accompanied by compulsive washing and checking, that increased in severity over time. About seven years ago she also developed obsessional doubts and checking compulsions. Initially she performed these rituals, but later she started asking her husband to check the gas stove and locks for her. When the husband complied once, she would not be convinced and she would again request him to repeat the checking behaviour. She would then ask to be reassured that he had checked everything thoroughly and that all was well. This would give her a sense of relief, but this relief was temporary; she would continue to insist that the husband repeat the ritualistic checking behaviours in this manner. Initially the husband considered her concerns to be normal. Later he thought it to be excessive, especially when his non-compliance resulted in her becoming very anxious and restless. They started having frequent altercations since these behaviours led to practical difficulties, such as the husband being late for his work due to her rituals. Further, the patient was unable to complete her household chores on time and neglected her personal care. She gradually began to avoid social functions.

During the past three years she also experienced several episodes of depression that lasted for a few months each time. These episodes were characterised by depressed mood, fatigability, decreased sleep and appetite, worthlessness, pessimistic views about the future and further deterioration in socio-occupational function. The last such episode was six months back. During this episode, she had experienced suicidal ideation but made no suicidal plans or attempts.

The patient was diagnosed to have migraine three years ago. She developed episodic, severe, left sided pulsatile headache, occurring 3-4 times a month and lasting for 3-5 hours each time. The headache increased in frequency to 2-3 times per week when the compulsive behaviours were more prominent. The headaches improved while on treatment for OCD, but on discontinuation of medication it reappeared, occurring upto 1-2 times per week. She resorted to over-the-counter analgesics for treatment of the headache. Additionally, she also developed vitiligo vulgaris about one year ago.

On interview and examination, the patient continued to have all obsessive compulsive symptoms described above. The patient had some intermittent sadness and difficulty in initiation of sleep, but she did not meet criteria for a depressive episode at the time of assessment. The Yale-Brown Obsessive Compulsive Scale score of 25 revealed severe obsessive compulsive symptoms and the Migraine Disability Assessment Scale score graded the migraine to be of a moderate nature. Routine laboratory investigations, including biochemical, hematological, electrocardiography and endocrine tests were normal, except for a microcytic hypochromic anaemia. She was diagnosed to be suffering from obsessive compulsive disorder, with comorbid recurrent depressive disorder, migraine and vitiligo vulgaris.

Prior to this presentation, the patient had been treated with clomipramine (up to 125mg daily), fluoxetine (up to 40 mg daily), as well as exposure and response prevention therapy. This had resulted in improvement of mood and sleep, but the washing and checking rituals remained

largely unchanged. The patient had subsequently discontinued medication due to daytime drowsiness.

After assessment this time, the patient was prescribed sertraline 100 mg, flunarizine 10 mg, iron-folic acid supplement daily and paracetamol as needed, for headaches. The nature of the illness was discussed with the husband and patient. A graded exposure and response prevention schedule was agreed upon, where the husband would gradually reduce complying to the patient's checking requests, over a period of weeks.

Following treatment for a month, significant improvement was observed in the patient's mood and sleep disturbances. A partial improvement was noted in her ritualistic behaviour. The husband had stopped complying with the patient's checking rituals, except on occasions when the patient developed severe anxiety. It was agreed to optimise medication, and to continue exposure and response prevention therapy, in which the husband was considered the co-therapist.

Discussion

This case illustrates an oft overlooked problem – the impact of long standing severe OCD on a family member, in the form of proxy compulsions. Proxy compulsions refer to anything done repeatedly by someone on behalf of a person with OCD, in response to an obsession. Accommodation is a broader concept that includes proxy compulsion, facilitating of rituals, and reassurance (2-4). These behaviours are often conceptualised as a requirement to maintain the balance in family (family system theory), a rewarding behaviour (social exchange theory) and a change in the caregiver's role and identity in relation to the care recipient (caregiver identity theory) (5). It inadvertently validates irrational thoughts, and reinforces the patient behaviour (6). The level of compliance (proxy compulsion or accommodation) depends upon the quality of interpersonal relationship, the personality of the person who carries out the proxy acts, the severity of OCD, the role of the person suffering from OCD and knowledge about the illness (3, 7).

There is no clear guideline for the management of compulsions by proxy. A few studies have reported that family based cognitive behaviour therapy (FB-CBT) and supportive parenting for anxious childhood emotions (SPACE) to be effective in family accommodation occurring in the context of paediatric OCD (8, 9). We have adopted the SPACE treatment method as it has been shown to be accepted by family members and associated with improved patient motivation (9). This method emphasises aspects such as self regulation, and provision of necessary support by collaboration with patients – for example, by reinforcing the patients' efforts, and helping to respond appropriately in face of anxiety; while maintaining a unified stance with regards to the compulsive rituals.

Challenges in the management of our patient included limited treatment response in the past, and poor past

treatment adherence. These are likely have been due to the use of suboptimal medication doses, as well as side effects. Since the patient showed improvement with the current treatment regimen of setraline 100 mg daily without significant side effects, it was decided to continue the same medication and optimise the dose to a maximum tolerated dose. This could be combined with appropriate augmentation therapy if needed particularly serotonergic enhancers (buspirone, ondansetron, pindolol, mirtazapine, clonazepam, memantine, riluzole) and antipsychotics (risperidone, haloperidol, aripiprazole) (10).

Sertraline was selected in this patient as it is effective in both depression and obsessive compulsive disorder, well tolerated, has less drug interactions and is helpful in reducing the severity of migraine in comparison to other serotonin reuptake inhibitors (SSRI) (11).

Obsessive compulsive disorder often co-occurs with migraine and depression (12). Severity of one disorder may worsen symptoms of the other and vice versa as observed in this patient. Hyposerotonergic function appears to be the underlying mechanism as seronergic drugs (tricyclic and selective serotonin re-uptake inhibitors) are helpful in treatment.

Compulsions by proxy is a rare presentation of OCD, which causes much disability to the patient and family, as described in this case report. While medication is important, non-pharmacological treatment, particularly involvement of family members or carers is crucial. Therefore they should be involved in the treatment plan and supported to work together with the patient, to improve longterm outcome.

Declaration of interest

None declared

Dushad Ram, Arun Kumar, JSS Medical College, JSS University, Mysore, Karnataka, India

Corresponding author: Dushad Ram

Email: dushadram@hotmail.com

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