IOSR Journal of Dental and Medical Sciences (IOSR-JDMS)
e-ISSN: 2279-0853, p-ISSN: 2279-0861.Volume 20, Issue 4 Ser.6 (April. 2021), PP 39-43
www.iosrjournals.org

Intrusive Thoughts and Obsessive-Compulsive Disorder

Ioana Alexa Florina Nonea[1], Andreea Anamaria Mirescu[1], Alexandru George Necşulescu[1], Ioana Radulescu[1], Simona Trifu[2]
[1]*Faculty of Psychology and Educational Sciences, University of Bucharest, Romania*
[2]*"Carol Davila" University of Medicine and Pharmacy, Bucharest, Romania*

Abstract:
Background*: Obsessive-compulsive disorder is an easily diagnosable disease, but it raises equally well in multiple differential diagnoses, given the "ease" with which it moves from the neurotic spectrum to the psychotic pole, when it becomes poorly critical or when the ideation reaches obsessive intensity.*
Materials and Methods*: The methods used were the initial psychological evaluation, the progressive one, the structured and unstructured clinical interview, psychoanalytic psycho-therapy cure, periodical psychiatric evaluation and treatment monitoring, psychoanalytic interpretations, analysis of transference and countertransference dynamics, the transgenerational analysis, the analysis of his social functioning, psychological monitoring, as well as the psychiatric treatment.*
Results*: The present case describes the need for this clinical delimitation for the nuanced exposure of a pathology of this bill. The explicit symptomatology of a patient with Obsessive Compulsive Disorder is a clinical challenge. We aim to highlight the underlying depression and impairment of social functioning. The patient works with money, has fixations from childhood in the hypochondriac area and in psychoanalytic thinking during the analytical period, later obsessive thoughts and representations being centered on loved ones (wife and children), as well as religion and faith. On closer inspection, we notice that childhood hypochondria later turns into OCD (with a minimum period free of symptoms) and after treating the area of obsession, the intensity of depression is even better highlighted.*
Conclusion: *A patient of this bill will "hide" major depression behind OCD; as well as depending on the stage of the disease may associate a greater or lesser criticism, in relation to the voluntary conscious effort involved in the act of repression (mostly unsuccessful).*
Key Word*: obsessive-compulsive disorder; paranoid personality disorder; hypochondria; fear; negative thoughts.*

Date of Submission: 29-03-2021 Date of Acceptance: 13-04-2021

I. Introduction

Obsessive Compulsive Disorder

Obsessive Compulsive Disorder (OCD) is different from Anxiety Disorder in that intrusive thoughts focus on illusory beliefs (also defined as "magical thinking") that are unrelated to reality, while in anxiety, thoughts are about aspects of everyday reality[1]. In other words, the patient "believes" that his own beliefs can take shape in real life, in his body - if he thinks something, it is enough for that thought to pass from the imaginary into reality. This belief is perceived by psychology / psychiatry as non-adaptive and pathological.

Moreover, patients are taught in therapy that these automatic thoughts are just thoughts and nothing more. The latest trend in psychotherapy, supported by cognitive behavioral therapy, refers to the bio-psycho-social model[2] and states that our thoughts influence our emotional feelings and, moreover, the social world in which we operate. In other words - when we want to delimit a pathological behavior - the influence of thoughts on reality is seen as an illusory belief - a maladaptive fact; and when we want to explain why some people feel and act differently from others, all based on cognition - beliefs, we realize how thinking influences reality, this fact being adaptive. But it is the same psychic phenomenon - our thoughts have the power to influence our reality. It is what Americans call a "double standard" - "a rule or principle that is unfairly applied in different ways to different people or groups"[3].

Follow-up of the patient from a psychiatric point of view in the following months after discharge, both to reduce medication and to reassess his mental state: in the case of the patient with OCD, the behavior comes from a belief in the "magic" spectrum / an unreal space, in which a single thought can distort or form a reality in the direction of that thought.

The person in question believes that if he thinks about the disease, it comes true and can appear in his own body. Following these beliefs, the patient ends up desperately looking for "a way out" and a return to

normalcy - he finds several "solutions" offered by contemporary society: doctors, hospitalizations, babes, healers and priests.

General data and context of the assessment

The 35-40-year-old patient, named M., is diagnosed with Obsessive Compulsive Disorder about which his wife knows, but she does not know the nature of the thoughts and the specifics of the patient's disorder. M. has finished 12 classes and is dealing with the usury. M has intrusive thoughts about his family. He says that although he loves his daughters and his wife very much, his thoughts insult them, which creates him mental discomfort. The man had a compulsive episode in the past that ended in 2017 after visiting a priest who read him prayers and reappeared in 2019 when he thought he was impotent. The patient has obsessive intrusive thoughts about his health. The patient is the only child of the family of origin.

The patient was hospitalized voluntarily, the present diagnosis being: Obsessive-Compulsive Disorder. The patient is worried about his obsessive thoughts about his own children and about God. He thinks his thoughts want to hurt him and those he cares about and he decides to be involved in a specialized intervention. He has charges against his drug treatment and in connection with his efficiency.

II. Material And Methods

In the present case, the methods used were the initial psychological evaluation, the progressive one, the structured and unstructured clinical interview, psychoanalytic psycho-therapy cure, periodical psychiatric evaluation and treatment monitoring, psychoanalytic interpretations, analysis of transference and countertransference dynamics, the transgenerational analysis, the analysis of his social functioning, psychological monitoring, as well as the psychiatric treatment.

III. Results

The M. suffers from a type of personality based on dependency and anxious attachment: fearful in the relationships around him, the acute need for help in all aspects of life, even if he declares himself independent. The cognitive pattern on failure and Hypochondria, constantly having the impression that he is not succeeding at anything and obsessively avoids all kinds of diseases, he tries to overcompensate. Also, another possible scheme would be abandonment, given the situation when his mother abandoned him in the hospital.

In addition, we can speak of an obsessive-compulsive disorder focusing perpetually on specific rituals[4], in an uncontrolled desire to avoid possible dysfunctions, diseases. This is based on the early abandonment of his mother in the hospital, an aspect still not integrated by M. in his life. He needs for constant and active reinsurance from those around him, especially from his wife, against whom he constantly manifests the fear of not being abandoned. At the same time, M projects a possible fear of those around him as to his ability to carry out his family and work-related responsibilities. He tries to do things on his own, but he finds it hard and can end up giving up. The patient had multiple hospitalizations as a child due to the mother's concerns about the possibility of developing certain health problems. During his hospitalizations, he was left alone, fact that made him feel abandoned by her at a very young age. As a child, he had sinusitis and he was treated with nasal drops based on ephedrine hydrochloride, for which he developed a long-term addiction[5].

The patient presents himself neatly and respectfully, being present in the conversation and attentive to its content, open to understanding what he is facing. He is cooperative and seems motivated to listen to and follow the instructions of the doctor, who is also present in the discussion. M seems to positively distort the information to create a positive impression on its content and himself, remembers and relates openly the current situation. It seems to create an unpleasant emotional state for him.

The man does not show qualitative changes in perceptions, as illusions or hallucinations, at the time of the interview. The man is focused, stable in conversation, present, coherent in speech, clear. Irritability arises in connection with the thoughts he has lack of self-confidence in the context of current symptoms and fear that he will not be able to manage the content of his thoughts and his own emotional states. The patient has hyper prosthesis about his health and thoughts with a negative connotation towards his family and other significant people in his life. No information is known about the objective evaluation of the patient by tests.

M. presents a functional thinking pattern, with hypochondriac and negative connotations due to the nature of obsessive, unfounded thoughts about his health, as well as those thoughts in which he swears at his family, children and other entities of significance to him, such as those related to the spiritual and religious area (as his priest, God- "thoughts cursed God", "I'm afraid to swear at my priest").

The patient presents mentisme[6], being the witness of his own thoughts that gain their own strength and appear in the form of ruminations and health concerns and in the form of curses and negative addresses causing anxiety and general anxiety to the patient. The patient finds it difficult to keep critical of thoughts, considering them uncontrollable and deeply disturbing ("I no longer know how to be a normal person"). The patient has thoughts centered on health and the danger of being ill. M. presents the obsessive idea that his thoughts swear at

his loved ones and the man feeling that he has no control over them. The obsessive idea that he is ill of an undiscovered disease is also present and he periodically performs health tests and investigations to calm his thoughts. His acute hypochondria with a possible origin from childhood, when his mother interned him frequently due to her suspicions that he had physical health problems. At the same time, M. presents a strong sense of conservation that accentuates hypochondriac thoughts, which lead to frequent and unsolicited medical testing by specialized staff.

Its suspicions are transposed on the child and persist until adulthood in the form of obsessive thoughts. M. has certain rituals that he does daily to calm down and to manage himself, and in difficult times he looks for contexts in which to learn new rituals as a measure of defense against anxious thoughts (he goes to the witch, to the shaman, to the priest). The risks of the illegal profession he carries out accentuate the intensity of his thoughts, offering additional reasons for concern both in relation to oneself and in relation to his loved ones.

In these case flattening or emotional blunting is not present, being in contact with his emotions and those of those around him. He can understand the possible emotions of his family if they sill discover the nature of his thoughts caused by the disorder he developed. M., presents accentuated negative affectivity at the moment of the interview as a result of the misunderstanding in relation to his own situation and the shame and guilt caused by that. He has a depressed attitude in response to obsessive thoughts. Feelings of loneliness and isolation in relation to the outside world and his own family, from which he hides the nature of his disorder. The wife is aware of the existence of some problems, but their nature is hidden from her in order to avoid the need for possible explanations. M is overwhelmed by anxiety and fear about his situation and his future.

M. has a strong motivation for healing from current problems, to take steps in this regard. He wants to feel "normal" in relation to the external environment and to remove the negative thoughts developed in relation to his own person, his family and the religious entities he respects (such as religion, etc.). M., has a high level of suggestibility against the background of hypochondriac seizures he presents.

M., considers that he has many enemies, possibly as a result of the service he practices and which is not in accordance with the legal norms, he is convinced that the psychological states he manifests are the result of powers he cannot control ("curses").

M., is convinced that the priest helped him in the first phase when he first went to him because of the belief that he was cursed by either relatives or acquaintances. He has a state of continual discomfort given that he is "cursed by God" and the belief it they can bring him bad luck. The belief that one's own thoughts are premonitions for various dis-eases and thus he can avoid them.

He believes in enchants and shamans. M., is seeking help from babes, healers, priests and shows the locus of external control and his need to be "saved" and protected. This aspect was learned as a small as well as the feel of danger. Christian values taken from parents and sustained throughout life by M., are an important spring in the patient's life, as he prays and goes to priests when needed to ensure him that he is healthy and normal, to believe that he is protected by his thoughts, that he is pure in his faith. M., is defensive when he describes the nature of his thoughts, assuring the interlocutor that he loves his children enormously and that the thoughts are not obscene or vulgar, but he is afraid of this aspect. Through this element, the man highlights his need to belong to the family and its importance to him, which is also present in connection with the family of origin that he fears he will lose due to old age and death.

Obsessive Compulsive Disorder in DSM-5 vision

People who suffer from obsessive-compulsive disorder have thoughts (eg, sexual thoughts about daughters, obsessive thoughts about health), mental ideas or images (eg, images of a sexual nature in relation to their daughters) that appear obsessively during a day[7]. People think that these ideas, thoughts or images are inappropriate and that they should not think that way. For this reason, the fact that these thoughts appear obsessively causes mental suffering of the patient. These thoughts can be related to hygiene, health (eg, health-related thoughts), the specific order of certain objects, insecurity about different things, eg, if M. can handle himself, if he does the right thing), unacceptable aggressive behaviors (not present in this case), or may be sexual in nature. To control the occurrence of these obsessions, people with this disorder resort to specific behaviors that block disturbing thoughts. These behaviors are called compulsions[8]. Compulsions can be excessive repetitive behaviors (such as hand washing or frequent health tests) or they can be mental in nature (thoughts that combat obsessions; going to sham-an, doctor, priest, prayers).

Summative symptomatology

•Manifests perfectionism that interferes with the fulfillment of the task (eg. he cannot complete an activity due to the thoughts that it is not good enough to carry it out);

•Is hyperconscious, scrupulous and inflexible in matters of morals, ethics or values (that is why inadequate thoughts about his own family and God cause him suffering);

•It has an inadequate model of rigid control, especially in relation to its state of health. It does not present a long-standing, generalized model of perfectionism.

Paranoid personality disorder in DSM 5 vision

PPD (Paranoid Personality Disorder) is assigned to individuals who have a pervasive, persistent, and enduring mistrust of others, and a profoundly cynical view of others and the world[7]. Persons with PPD are hypervigilant to physical, verbal or social attacks, and do not trust others, and therefore tend to have few if any close or intimate associates. They tend to be aloof, cold, distant, argumentative, and frequently complain. They may appear guarded and secretive, very rational, logical, and unemotional, but at times will be sarcastic, hostile, and rigid. Generally, they have a difficult time getting along with others people with Paranoid Personality Disorder, tend to do poorly with group activities and collaborative projects. Paranoid Personality Disorder is a non-psychotic disorder[9], in that it is a discrete diagnosis involving one's dysfunctional and maladaptive personality characteristics, rather than a thought or mood disorder. Persons with Paranoid Personality Disorder may develop brief psychotic reactions under stress, but by definition, a brief psychotic episode is discrete and does not endure.

Summative symptomatology:

•The person with PPD will believe others are using, lying to, or harming them, without apparent evidence thereof (he believes that a power wants something evil for him, that it has unknown enemies)
•They will have doubts about the loyalty and trustworthiness of others (M.'s family does not know the nature of his illness).
•They will not confide in others due to the belief that their confidence will be betrayed.
•They will interpret ambiguous or benign remarks as hurtful or threatening,

Risk and prognosis factors:

Cognitive factors - people with OCD associate certain objects or situations with a strong sense of fear, so they learn to avoid those things or perform "rituals" to reduce their fear. M. manifests this fear in connection with the nature of his thoughts and the possibility of implementing them involuntarily. The rituals are based on frequent visits to shamans, doctors and representatives of this sphere.

Genetic factors - even if she is not diagnosed, M.'s mother has symptoms specific to obsessive compulsive disorder due to the nature of her obsession with her son's health.

Personality - the paranoid personality favors the development of obsessions in relation to his personal life.

IV. Discussion

The diagnosis of obsessive-compulsive disorder remains valid. We can see that the patient perceives himself as something "abnormal", a man with abnormal thoughts, ab-normal behaviors and even unfounded worries, which takes over most of his life. His thoughts accentuate this feeling, as well as his guilt, as well as his shame towards his own person and the content of his own thoughts.

We provide specific medication for the disorder in question (Risperidone, Seroxat, Sertraline, Diazepam).

His hospitalization for a certain period - at least until the relief of symptoms in the depressive spectrum and obsessive-compulsive disorder

We encourage providing a psychotherapeutic treatment for the relief of depressive symptoms and resolving the cognitive patterns mentioned above for a period of at least 6 months after discharge.

V. Conclusion

In the case of our patient, the obsessive-compulsive disorder translates into hypochondria, the absolute need to avoid different diseases. They turn to all the help that comes their way, whether scientific or magical, from priests and grandmothers to doctors and nurses. Also, the absolute belief that an occult power controls his life, "God cursing him" but also the curses of those around him for the actions taken.

References

[1]. Goodwin GM. The overlap between anxiety, depression, and obsessive-compulsive disorder. Dialogues Clin Neurosci. 2015;17(3):249-260.
[2]. Mancini MA. The Intersections of Social, Behavioral, and Physical Health. Integrated Behavioral Health Practice. 2020;25-57.
[3]. Levine S, Kleiman-Weiner M, Schulz L, Tenenbaum J, Cushman F. The logic of universalization guides moral judgment. Proc Natl Acad Sci U S A. 2020;117(42):26158-26169.
[4]. Stein DJ, Costa DLC, Lochner C, et al. Obsessive-compulsive disorder. Nat Rev Dis Primers. 2019;5(1):52.
[5]. Sun Z, Ma Y, Duan S, et al. cAMP Response Element Binding Protein Expression in the Hippocampus of Rhesus Macaques with Chronic Ephedrine Addiction. Biomed Res Int. 2017;2017:1931204.

[6]. Egloff N, Hirschi A, von Känel R. Traumatization and chronic pain: a further model of interaction. J Pain Res. 2013;6:765-770.
[7]. American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders (5th ed.). Arlington, VA: Author.
[8]. Luigjes J, Lorenzetti V, de Haan S, et al. Defining Compulsive Behavior. Neuropsychol Rev. 2019;29(1):4-13.
[9]. Lee R. Mistrustful and Misunderstood: A Review of Paranoid Personality Disorder. Curr Behav Neurosci Rep. 2017;4(2):151-165.

Ioana Alexa Florina Nonea, et. al. "Intrusive Thoughts and Obsessive-Compulsive Disorder."*IOSR Journal of Dental and Medical Sciences (IOSR-JDMS)*, 20(04), 2021, pp. 39-43.