COGNITIVE BEHAVIORAL CASE CONFERENCE
A Case of Obsessive-Compulsive Disorder

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This article presents the case of a 51-year old woman with obsessive-compulsive disorder. “Caroline” reported obsessions of harming people secondary to spreading her “bad energy,” which is experienced as dust on her hands and in her mouth. To prevent harm coming to others she mentally “vacuums” the dust, creates mental protective barriers around nearby people and avoids touching others for fear of transmitting her bad energy. Although she reported a childhood onset of obsessions and compulsions, it exacerbated in the context of multiple stressors 4 years prior to seeking treatment. Her Yale-Brown Obsessive Compulsive Scale total score was in the moderate range at intake. Predisposing, precipitating, and maintaining factors are described in addition to the specific symptom presentation.

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his paper serves as the clinical example for the four papers contained in this cognitive behavioral case conference. It differs from other case studies in that it is only a description of a client and not a case conceptualization and treatment. It is akin to a detailed diagnostic evaluation. The information is written as objectively as possible so that one treatment approach does not seem more appropriate over another. The client gave her full consent to participate in this series. Some of her information was altered to respect her anonymity.

Demographic Information

Caroline is a 51-year-old married Caucasian woman who lives with her husband in a large metropolitan city in North America. She wanted to have children, but unfortunately has none of her own. She is the first in a sibline of three. She owns and works at a private business with her husband. Caroline’s free time is largely spent with her extended family.

She was referred for psychological treatment of her OCD by her family physician. Two years prior to her intake Caroline began taking Citalopram (40 mg QD) and L-thyroxin (50 mg QD), and has never received psychotherapy for her anxiety. She denied use of alcohol or recreational drugs and does not smoke cigarettes.

Primary Presenting Problem

The clinician version of the Yale-Brown Obsessive Compulsive Scale (YBOCS; Goodman, Price, Rasmussen, Mazure, Delgado, et al., 1989; Goodman, Price, Rasmussen, Mazure, Fleischman, et al., 1989) was used to establish OCD severity and symptom presentation. Caroline’s principal symptom is a fear that she will indirectly harm others by her mere presence and it is therefore her duty to protect the world from herself. Everyone she encounters is potentially in danger, including people she passes in cars, on the street, or in her store, but she is especially concerned about friends, family members, and children.

Caroline believes that she is able to spread her “bad energy” (created by intrusive unwanted thoughts), which is in the form of “dust” on her hands and tongue. She began getting this dusty feeling on her hands at around age 10 when her mother was hospitalized due to a severe fall while pregnant. She used to flick her fingers to get rid of the “dust coated” feeling. However, since her best friend’s death, she began to fear that flicking her fingers would spread the dust and bad energy. Instead, she closes her hands into fists. She also bites the sides of her tongue to “dissolve” the dust so the “bad particles” do not spread to others. She reported that if she does not do something about the “dust,” her bad energy will spread to the abdominal area or head of anyone who is around her and something bad will happen to these people (e.g., illness, injury, death).

If Caroline is unable to “contain” her bad energy, she says a prayer (e.g., asking God to keep the person healthy) or says the phrase “just goodness” to ensure someone’s well-being. She avoids saying “good-bye” when getting off the phone or parting with someone for the fear of bringing harm to the person and substitutes phrases that include “take care.” Moreover, she always wipes her hands thoroughly with hand wipes before visiting someone who is ill. After each visit, she immediately wipes her hands, washes her clothes, and takes a shower for fear of spreading illness to others. She also asks...
her husband to do the same, except for showering, to protect him from illness.

Caroline was considerably late for both her assessment appointments. She disclosed at the end of the second assessment that she had conflicting feelings about seeking treatment. By helping herself in seeking treatment, she believed that she was putting others in danger (i.e., she was taking the place of someone who deserved the therapist’s time). In response to this fear, she sought reassurance in the form of prayer.

In addition to her fear of causing harm, she also fears not being able to prevent harm, especially cancer, from others. Caroline feels compelled to protect everyone around her to prevent the spread of the illness. One of Caroline’s strategies is to create an imagined circle around each person she wants to protect and “pulls” the circle containing the bad energy away from the person. Alternate means of protecting others include prayer, raising her eyebrows, and blinking her eyes until she feels that the person is protected. Caroline also has intrusive fears of herself having cancer. These intrusions trigger “dust coated” feelings on her hands and tongue, and she reportedly uses the same strategies described above to prevent the feared consequences.

**Other Mental Health Problems**

Caroline has always been self-conscious, stating that she “feels inferior on a human scale because she does not measure up to others.” She has particular difficulty attending parties (even when accompanied by her husband), public speaking, writing and eating in public, using public restrooms, talking to persons in authority, being assertive (e.g., refusing unreasonable requests or asking others to change behavior,) and initiating/main- taining a conversation. Her primary feared consequence is not meeting other’s expectations or embarrassing her family members. These situations cause considerable anxiety and she avoids them whenever possible. To avoid attracting attention, Caroline does not wear bright colors or fitted clothing. She wishes that she could be less concerned about social evaluation as it interferes with her social functioning (e.g., she did not join a recreational soccer team because of her social anxiety).

Caroline reported that the only time in her life that she struggled with low mood was during a 3-week period after her first miscarriage. During that time, she experienced depressed mood most of the day nearly everyday, increased appetite, feelings of worthlessness and guilt, and poor concentration.

**Behavioral Observations**

Caroline presented as a warm and friendly individual but clearly very hesitant about getting too close to people. She politely declined shaking the interviewer’s hand, indicating that she had a cold. She fidgeted throughout the interview and occasionally exhibited facial twitches and constant movement of one leg. Her timidity comes across in her posture and dress. She was wearing muted colors and dressed in shapeless clothing.

**Pertinent Historical Information**

Caroline’s parents met when they were approximately 18 years of age. Her mother was living at home while attending college, and her father relocated to work in the same geographical area. While the two were dating, late-night rendezvous occurred in the maternal home unbeknownst to Caroline’s grandparents. It is unclear how many times the latter occurred. As a result of one of these late-night encounters the couple had an unplanned pregnancy. The pregnancy was devastating for Caroline’s mother but her father was more accepting of the situation.

As a result of this pregnancy, Caroline’s mother ceased her college education and married Caroline’s father. To survive financially, the couple relocated from an urban area to a rural one, approximately 6 hours away. Her mother was deeply resentful of these abrupt changes in her life. She wanted to complete college and did not want to move. There was nothing notable about the birth of Caroline, but the changes in her mother’s life had a lasting impact on the mother. The mother blamed her newborn child, Caroline, for her unhappiness, often saying, “I made one mistake one night and paid for it for the rest of my life.” Much later in life, Caroline learned from her father that her parents had multiple sexual encounters prior to the mother becoming pregnant. Caroline’s mother was very angry with her husband for having revealed this information, possibly because it was in sharp contrast with what Caroline was told. The pregnancy was clearly not the result of a “one-time mistake.”

Throughout Caroline’s childhood, her mother often complained about how her life would have been better had she not had to drop out of college, marry her father, move to a rural area, and start raising a child at such a young age. This resentment plus her mother’s struggle with an undiagnosed mood disorder created a tense and uncomfortable household. Her parents fought regularly but Caroline was usually the recipient of her mother’s verbal and physical abuse. This pattern never changed throughout Caroline’s life and she continued to receive the majority of the abuse. The rest of the family was somewhat spared from it, including her father who could not cope with his wife’s mood swings and often avoided being home.

From a young age, Caroline believed she played a major role in her mother’s unhappiness and tried her hardest to make amends. Throughout her life, Caroline worked to assist her mother, including currently spending approximately 2 days a week with her, providing emotional support and functioning as her caretaker.
She shielded her siblings from her mother because she felt they had more important things to do and did not want to disrupt their lives. She did not find this work rewarding but more of a commitment that she was obligated to complete. Her mother was seldom grateful for the work that Caroline did and continued to be critical of her. Over the years, Caroline’s mother became more dependent on her and she felt increasingly responsible for her mother’s well-being. The mother’s mood swings became more frequent and severe. For example, in her twenties, Caroline went away on vacation and her mother attempted suicide while she was away. Caroline became increasingly distressed and physically depleted as a result of her attempts to please her mother.

Despite multiple pregnancies, Caroline was never able to have a child. She became pregnant four times but suffered miscarriages with each pregnancy. Caroline and her husband also worked with a fertility clinic, but that too was unsuccessful. There was no medical reason identified for her inability to sustain her pregnancies. Although her husband did not see Caroline as the cause of these problems, she believed that it was God intervening, not wanting another of her to be born.

**Precipitating Factors**

Caroline reported that her problems with obsessions and compulsions date back to age 10; however, she was not diagnosed with OCD until she was 49. From the age of 10 until 49 she mainly struggled with mild forms of contamination that was not associated with illness (i.e., she didn’t like the feeling of contamination). Although her symptoms have waxed and waned over the years, they exacerbated at 47 years of age in the context of multiple stressors. At that time she battled with several physical illnesses (hyperthyroidism, intestinal inflammation that resulted in significant weight loss, and abnormal cells in her Pap smear that were ultimately determined to be noncancerous). Prior to these illnesses Caroline’s best friend had a massive heart attack and died. Caroline believed she was to blame for her friend’s death as the friend was experiencing unexplainable symptoms in the weeks prior to her heart attack. Caroline urged her to go to her physician but the advice was not heeded. Caroline was convinced that she played a role in the death of her friend as she did not continue to push her to seek help. Caroline believed from then on that her presence not only made others vulnerable to bad things happening, but she could also cause people to die. Caroline then became ill, which made her believe that she was next in line to die. When she recovered she believed that somebody else was going to die instead, which made her feel more protective of those around her.

While receiving treatment and decreasing her compulsive behaviors, her sister was hospitalized involuntarily for 7 days with a psychotic break. Her sister worked full time in a professional job with no history of significant psychotic symptoms. Caroline recalled on one occasion approximately 10 years ago similar problems but much less acute and they receded without intervention. However, her sister has a history of fractious interpersonal relationships, never married, and is socially isolated. As the psychotic break occurred in conjunction with decreasing her compulsive behaviors, Caroline blamed herself for her sister’s hospitalization. The sister also blamed Caroline as it was she who drove the sister to the hospital. She is currently not speaking to Caroline.

**Questionnaire Data**

Caroline completed the YBOCS, a clinician-completed semistructured interview that assesses the severity of obsessions and compulsions. There are 10 scored items that are rated on a 0- to 4-point scale, with lower numbers representing less severity of obsessions and compulsions. Summing these scores results in an overall score for OCD and subscores for obsession and compulsion severity. The total score ranges from 0 to 40 and the subscales range from 0 to 20. The mean score on the YBOCS for individuals diagnosed with OCD is 21.9, and the mean obsession and compulsion subscores are 10.7 and 11.2, respectively (Goodman, Price, Rasmussen, Mazure, Fleischman, et al., 1989). The YBOCS also has nine investigational questions that measure insight, avoidance, indecisiveness, perceived responsibility, slowness, pervasive doubting, global severity, and global improvement.

Caroline received a total score of 22 on this measure with scores of 10 on the compulsion subscale and 12 on the obsession subscale. She reported that her obsessions and compulsions were present between 3 and 8 hours a day each, and that she could not last longer than an hour without having an obsession and performing a compulsion. She acknowledged that her obsessions are unreasonable but was not completely convinced. While working with her it became apparent she actually had poor insight, as she did not believe that her obsessions were unreasonable, and evidence to the contrary did little to change this belief. She reported mild to moderate avoidance of situations that cause obsessions. For example, she will avoid touching certain public items for fear that she might spread her dust. She avoids touching other people, and especially avoids being around children and people who are ill because they
are especially susceptible to her dust. She has mild decision-making difficulties about minor things. Her sense of responsibility is extreme in that she often fears that she might have affected events for which she did not participate. For example, when hearing of an airplane or ship accident, she will question whether she came into contact with someone before they boarded the vehicle, thus causing the accident. She has no difficulty starting or finishing tasks, and has only mild doubt regarding whether she performed an activity correctly. Her global severity was rated as mild with little functional impairment, although this rating also seems low, as it requires a high degree of effort to perform daily activities.

References


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