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Letter to the Editor
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Life Paralyzing Obsessive Compulsive Disorder: A Case of Flexion Contracture

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To The Editor

Obsessive-Compulsive Disorder (OCD) is a prevalent, chronic, and disabling mental health condition that significantly impacts global functionality.Obsessive-Compulsive Disorder often involves family dynamics, as family members may inadvertently reinforce compulsive behaviors through family accommodation (FA). Family accommodation includes providing reassurance, participating in rituals, or modifying family routines to alleviate patient distress. While these behaviors may offer temporary relief, they ultimately exacerbate the severity of OCD symptoms and functional impairment.[2] This report presents a unique case of a bedridden OCD patient without any comorbid physical diagnoses. To the authors' knowledge, this is the first such case documented in the literature. The patient's caregiver, her husband, also demonstrated significant involvement in maintaining her rituals, highlighting the critical role of FA in this case.

The written informed consent was provided by the patient for patient information to be published. The patient is a 53-year-old married woman with a 32-year history of OCD, who has 1 son and is not in contact with her family. Despite initial short-term pharmacological interventions, the absence of sustained treatment led to chronic and worsening symptoms. She first sought psychiatric help 4 years after the onset of symptoms and has had intermittent psychiatric clinic visits until the last 2 years. During this period, she used medications such as fluvoxamine, sertraline, sulpiride, trifluoperazine, risperidone, and remembers experiencing partial benefit from the treatment with zuclopenthixol, but discontinued it due to weight gain. There was no period during this time in which she reported a complete remission of symptoms. Her symptoms include fears and concerns about not being sure of completing her toileting needs and worries about cleaning herself after using the toilet. To avoid the need to repeat the entire toilet process, she spends an excessive amount of time sitting on the toilet, often consuming 5-6 hours daily, sometimes up to 24 hours. She also avoided food and fluid intake to minimize her need for the toilet. As a result, she developed pressure sores and knee contractures due to prolonged sitting, which ultimately rendered her bedridden for the past 6 years Figure 1. The patient refrained from using her hands to avoid contamination, keeping them positioned at chest level and in front of her eyes, moving them but not using them. Despite no limitations in her arm movements, her husband fed her and assisted with her toileting needs using incontinence pads. Her husband assumed the role of primary caregiver, ceasing employment to provide constant reassurance and assistance with her compulsions.The patient's condition culminated in a fall, prompting her first hospitalization. Initial assessments revealed severe malnutrition, poor physical health, and extensive FA. The mental status examination showed that the patient was fully conscious, oriented, and cooperative, with a anxious mood and appropriate affect. No delusions or hallucinations were detected. The content of her thoughts included contamination and cleaning obsessions, and her insight was limited. Multidisciplinary interventions included psychiatric evaluation, physical therapy, and wound care. Pharmacological treatment with fluoxetine was initiated at 20 mg/day and

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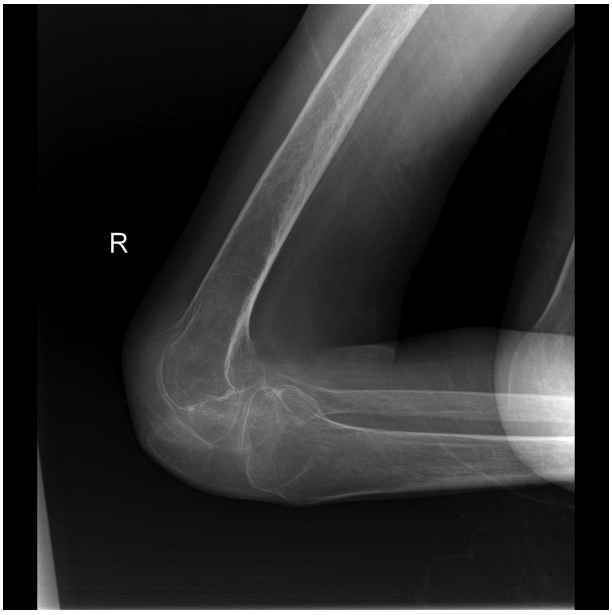

Figure 1. Right knee flexion contracture.

increased to 60 mg/day, alongside paliperidone treatment at 6 mg/day. During the 43-day hospitalization, daily exposure and response prevention (ERP) therapy and therapeutic sessions were conducted. Initially, detailed information about OCD and ERP was provided, and a treatment plan was developed. The therapy involved both imagined exposures and gradual, in-clinic exposure exercises, where the patient was helped to tolerate discomfort and uncertainty without engaging in compulsions, while also learning that feared outcomes did not occur. Over the course of her hospitalization, the patient demonstrated significant improvement, with a reduction in her Yale-Brown Obsessive-Compulsive Scale (Y-BOCS) score from 40 to 12. She gained 10 kg, regained some mobility, and began using a wheelchair to socialize. Although the husband did not have any diagnosable psychiatric disorders, he displayed dependent personality traits. Psychoeducation regarding obsessive-compulsive disorder (OCD) and was provided to him, along with information about the impact of his involvement in the patient's care. Despite his supportive intentions, the negative consequences of his excessive facilitation of the patient's personal needs were emphasized. During the patient's hospitalization, separate time for the husband and patient was planned, with gradually increasing intervals. Furthermore, activities aimed at enhancing the husband's social engagement, such as pursuing a new job, hobbies, walking, or meeting with friends, were encouraged. Various interventions were implemented to strengthen the husband's social connections throughout this process. With the interventions provided to the husband, the patient's therapy adherence improved.

This case underscores the profound physical and psychosocial impact of severe OCD and highlights the critical role of FA in the disorder's progression and prognosis.[3] The patient's bedridden state, a rare complication, illustrates the severe functional impairments that can arise when OCD remains untreated or poorly managed.[4] The husband's extensive involvement in the patient's rituals, though well-intentioned, perpetuated the chronicity of her condition. This finding aligns with existing literature, which emphasizes the adverse outcomes of FA in OCD management. Additionally, in this case, factors such as the patient's caregiver being the spouse, the patient having contamination obsessions, the limited response to previous treatments, and the prolonged duration of the symptoms, have been factors that, in line with the literature, have reinforced FA.[5] Effective treatment requires addressing both the patient's symptoms and the family dynamics that sustain them. Future research should explore the development of targeted interventions for FA and their impact on treatment outcomes in severe OCD cases. Psychoeducation for families and early intervention for patients are critical to preventing such debilitating complications.

Data Availability Statement: The data that support the findings of this study are available on request from the corresponding author.

Informed Consent: Written informed consent was obtained from the patient.

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