

Recognition and Collaborative Management of Contamination-Related Obsessive-Compulsive Disorder in Primary Care: A Case Report

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Abstract

Background: Obsessive-compulsive disorder (OCD) is frequently missed in primary care because patients may conceal symptoms or present only after substantial functional impairment. Early recognition and coordinated care can reduce disability.

Case presentation: A woman in her early twenties presented with a four-year history of contamination-related intrusive thoughts and prolonged repetitive bathing. She recognised that the thoughts and rituals were excessive but experienced marked anxiety when resisting them. Bathing occupied several hours and caused recurrent lateness to school. There was no evidence of psychosis, mania, substance use or a primary medical explanation in the supplied history.

Intervention and outcome: The family physician provided psychoeducation, involved the patient's supportive spouse with her consent, referred her for cognitive behavioural therapy incorporating exposure and response prevention, and commenced paroxetine. Symptoms improved over serial follow-up, bathing time reduced to approximately 10-15 minutes and rituals ceased. Medication was later tapered and discontinued. Exact treatment duration and standardised severity scores were not supplied.

Conclusion: Primary-care clinicians can improve detection by asking directly about intrusive thoughts, repetitive behaviours, time consumption and functional impairment. Effective care requires accurate diagnosis, risk assessment, evidence-based CBT/ERP, appropriate pharmacotherapy, monitoring and referral or shared care when needed.

Keywords: obsessive-compulsive disorder, contamination, washing compulsions, exposure and response prevention, primary care, case report

Introduction

Obsessive-compulsive disorder is characterised by obsessions, compulsions or both. Obsessions are recurrent intrusive thoughts, images or urges that cause distress; compulsions are repetitive behaviours or mental acts performed to reduce distress or prevent a feared outcome. Symptoms are time-consuming or cause clinically significant distress or impairment [1-3]. Lifetime prevalence is commonly estimated at approximately 1-3%, and delayed recognition is frequent [2].

Evidence-based treatment includes cognitive behavioural therapy incorporating exposure and response prevention (ERP), serotonin reuptake inhibitors, or both, selected according to severity, preference, comorbidity and access [2-5]. Family physicians may identify OCD, assess medical and psychiatric differentials, initiate treatment within competence and coordinate psychological or specialist care. This report describes contamination-

related OCD recognised in a primary-care setting and managed collaboratively.

Case presentation

Patient information and presenting concern

A married woman in her early twenties attended a family-medicine clinic with her husband because of excessive washing during bathing. The problem had begun at approximately 18 years of age and had worsened over four years. She repeatedly feared that parts of her body, particularly her back, remained contaminated or unwashed despite recognising that she had washed them.

Attempts to leave the bathroom produced marked anxiety and a sense of incompleteness. Rewashing reduced distress temporarily. She developed a spoken running commentary while bathing to reassure herself that each body area had been washed. Bathing could take several hours and caused recurrent lateness to school. Her husband sometimes interrupted the ritual. She feared that others might

interpret her behaviour as mental illness, but retained insight and believed treatment could help.

Relevant history

The supplied history did not identify sustained depressed mood, loss of interest, manic symptoms, hallucinations, delusions, substance use or symptoms suggesting hyperthyroidism. There was no reported previous psychiatric history or known family psychiatric history. She was not taking medication and reported no drug allergies. She was of reproductive potential; pregnancy status, contraceptive plans and reproductive counselling were not documented.

Clinical and mental-state findings

Physical examination was generally unremarkable. She appeared anxious but was appropriately dressed, cooperative and coherent. Mood and affect were described as normal. Thought content included recurrent intrusive contamination thoughts and washing-related incompleteness without delusions. No hallucinations or formal thought disorder were reported. Orientation, cognition, judgement and insight were preserved.

Diagnostic assessment

The working diagnosis was contamination-related OCD with washing compulsions. The symptoms were intrusive, resisted, recognised as excessive, time-consuming and functionally impairing. Generalised anxiety disorder was considered, but the circumscribed obsession-compulsion cycle and ritualised washing were more characteristic of OCD. Other relevant differentials include illness anxiety, body dysmorphic disorder, psychotic disorder,

depressive rumination and repetitive behaviour secondary to a medical or substance-related condition. The supplied record did not include a standardised severity score.

Therapeutic intervention

The patient and her husband received psychoeducation about the obsession-anxiety-compulsion cycle. With the patient's agreement, her husband was encouraged to support treatment without repeatedly reassuring her or forcibly participating in rituals. She was referred to a clinical psychologist for CBT incorporating ERP. Behavioural work included monitoring triggers and rituals, graded reduction of repeated washing, leaving the bathroom after a planned routine, resisting return to rewash and recording symptom frequency. These tasks should be collaboratively graded rather than framed as simple thought suppression.

Paroxetine 20 mg daily was started after discussion of expected benefits and adverse effects and was increased to 30 mg daily after three weeks because improvement was limited. The historical treatment is reported as provided; the record should clarify pregnancy assessment, reproductive counselling, shared decision-making and the rationale for selecting paroxetine.

Follow-up and outcomes

No adverse effects, withdrawal symptoms, relapse or standardised outcome scores were reported. The duration of remission after discharge was not supplied.

Table 1. Longitudinal clinical course, pharmacological adjustments, and psychotherapeutic interventions

Time point	Clinical course and intervention
Baseline	Several-hour bathing rituals, contamination thoughts, running commentary and school lateness; psychoeducation, CBT/ERP referral and paroxetine 20 mg daily.
3 weeks	Minimal improvement; fewer returns to the bathroom; two CBT sessions reported; paroxetine increased to 30 mg daily; symptom-monitoring chart introduced.
Approximately 7 weeks	Marked reduction in intrusive thoughts and rituals; medication and CBT continued.
Approximately 3 months	Sleeping better; bathing reduced to 10-15 minutes; running commentary and repeated washing no longer reported.
Subsequent visits	Symptoms reportedly remained absent through serial follow-up. Paroxetine was gradually tapered and discontinued by the tenth visit; exact dates and taper schedule require confirmation.

Discussion

This presentation illustrates a common OCD pattern: contamination obsessions, washing compulsions, preserved insight and a sense of incompleteness. Functional impairment became visible through prolonged bathing and school lateness. People with OCD may delay disclosure because of shame, fear of stigma or uncertainty that symptoms are treatable [1-3]. Direct but sensitive questions in primary care can improve detection.

ERP is a first-line psychological treatment. It involves planned exposure to obsessional triggers while preventing or delaying the usual ritual, allowing distress and threat expectations to reduce without compulsive neutralisation. SSRIs are first-line medicines, often requiring an adequate dose and longer trial than in depression [2-5]. Network meta-analysis supports both behavioural/CBT approaches and serotonin reuptake inhibitors for adults with OCD [5].

The case also shows the value and risk of family involvement. A supportive relative can encourage attendance and reduce accommodation, but coercive interruption or repeated reassurance may increase conflict or maintain rituals. Involvement should be guided by the patient's consent, privacy and treatment plan.

Family physicians can recognise symptoms, assess impairment and comorbidity, initiate psychoeducation and appropriate medication, monitor safety and coordinate psychological care. Referral is indicated where diagnosis is uncertain, symptoms are severe, suicide risk or major comorbidity is present, first-line treatment fails, or specialist augmentation is considered [3,4].

The report has important limitations. It is a single case, lacks a validated severity measure and does not provide a complete treatment or relapse-prevention timeline. The improvement cannot be attributed separately to CBT, medication, family support or natural fluctuation. Reproductive-safety assessment and written consent for publication must be confirmed.

Conclusion

Contamination-related OCD may present in primary care through prolonged washing, reassurance behaviours and functional delay. Recognition depends on asking about intrusive thoughts, rituals, time consumption and impairment. Coordinated CBT/ERP and appropriate SSRI treatment can be effective, but care should include safety assessment,

reproductive counselling where relevant, measurement-based follow-up, family-boundary guidance and relapse prevention.

References

1. Goodman WK, Grice DE, Lapidus KAB, Coffey BJ. Obsessive-compulsive disorder. *Psychiatr Clin North Am.* 2014;37(3):257-267. doi:10.1016/j.psc.2014.06.004.
2. Hirschtritt ME, Bloch MH, Mathews CA. Obsessive-compulsive disorder: advances in diagnosis and treatment. *JAMA.* 2017;317(13):1358-1367. doi:10.1001/jama.2017.2200.
3. Veale D, Roberts A. Obsessive-compulsive disorder. *BMJ.* 2014;348:g2183. doi:10.1136/bmj.g2183.
4. National Institute for Health and Care Excellence. Obsessive-compulsive disorder and body dysmorphic disorder: treatment. Clinical guideline CG31. London: NICE; 2005, reviewed 2024.
5. Skapinakis P, Caldwell DM, Hollingworth W, et al. Pharmacological and psychotherapeutic interventions for management of obsessive-compulsive disorder in adults: a systematic review and network meta-analysis. *Lancet Psychiatry.* 2016;3(8):730-739. doi:10.1016/S2215-0366(16)30069-4.
6. Grant JE. Obsessive-compulsive disorder. *N Engl J Med.* 2014;371(7):646-653. doi:10.1056/NEJMcp1402176.
7. Pittenger C, Bloch MH. Pharmacological treatment of obsessive-compulsive disorder. *Psychiatr Clin North Am.* 2014;37(3):375-391. doi:10.1016/j.psc.2014.05.006.
8. Opakunle T, Aloba O, Akinsulore A. Obsessive-compulsive inventory-child version: confirmatory factor analysis, reliability, validity and correlates among Nigerian adolescents. *Malawi Med J.* 2018;30(4):262-269. doi:10.4314/mmj.v30i4.9.
9. Gagnier JJ, Kienle G, Altman DG, Moher D, Sox H, Riley D; CARE Group. The CARE guidelines: consensus-based clinical case report guideline development. *J Clin Epidemiol.* 2014;67(1):46-51. doi:10.1016/j.jclinepi.2013.08.003.

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