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# Obsessive–Compulsive Disorder and Post-Traumatic Stress Disorder: About a Case

Anouar KADDAF[1]*, Zakaria HAMMANI[2], Mohamed KADIRI[3]

[1,3]Department of Psychiatry, Military Hospital of Instruction Mohamed V, Rabat
[2]Department of Psychiatry, Military Hospital of My Ismail, Meknes

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***Corresponding author:** Anouar KADDAF
Department of Psychiatry, Military Hospital of Instruction Mohamed V, Rabat

**Abstract** **Case Report**

Obsessive–compulsive disorder (OCD) is a mental illness that affects 2–3% of the general population and can make everyday life very difficult. An expanding corpus of epidemiological, theoretical, and clinical evidence demonstrates a significant association between particular symptoms of OCD and traumatic experiences or post-traumatic stress disorder (PTSD). We discuss the case of a 43-year-old Syrian refugee who developed severe contamination-related OCD following a prolonged period of untreated PTSD symptoms. The patient displayed incapacitating washing behaviors in a refugee camp marked by limited water access. She got the right medicine and therapy, but her symptoms only got better for a short time. A lot of interviews showed that she had been through a lot of hard times, like seeing her brothers die and being sexually assaulted. The patient's OCD symptoms appeared to be an unproductive method for managing PTSD intrusions. They helped with emotional pain, but they also made things worse in a lot of ways. This case illustrates the complex interplay and possible reciprocal compensation between OCD and PTSD symptoms, highlighting the need for integrated therapeutic approaches rather than treating OCD in isolation. It also talks about mental contamination, which is when you feel dirty just by touching something. We need to do more research to learn more about the link between OCD and PTSD, how to spot them better, and whether there should be a certain type of OCD that happens after trauma.

**Keywords**: Obsessive–compulsive disorder, post-traumatic stress disorder, Mental contamination, Trauma-related OCD, Comorbidity, Refugee mental health, Case report, Anxiety disorders, Cognitive-behavioral therapy, Exposure and response prevention.



## INTRODUCTION

Obsessive–compulsive disorder (OCD) is a psychiatric disorder that affects 2–3% of the general population. It causes significant psychological distress with potentially disabling repercussions on daily life. [1] Numerous epidemiological studies, as well as strong theoretical and clinical indications, support a relationship between certain forms of OCD and traumatic events or post-traumatic stress disorder (PTSD). [2] In some cases, the connections between PTSD and OCD symptoms are obvious (for example, a person who has been robbed develops a persistent sense of "danger" and subsequently adopts compulsive door- and lock-checking behaviors). However, in other cases, these connections may be less apparent and require careful examination and further evaluation.

### Clinical Vignette

Mrs. N., a Syrian refugee in Jordan, is 43 years old and the mother of 5 children. She was followed for 4 months for OCD characterized by an overwhelming feeling of being dirty and contaminated, accompanied by repeated rituals of washing her hands and body (5 to 6 showers per day), in stark contrast with the very limited amount of water allocated to each family in the refugee camp.

The patient was started on therapeutic doses of tricyclic antidepressants and benzodiazepines, combined with psychotherapy sessions. Her clinical course was marked by slight improvement at first, followed by rapid regression, with symptoms persisting despite good treatment adherence. After several consultations, repeated interviews, and the establishment of trust, a history of trauma was eventually disclosed—something the patient had been unable to reveal earlier due to

overwhelming shame. She had witnessed the murder of her two brothers before being raped in the same room. She lost consciousness and later awoke covered in blood, which she presumed to be that of her murdered brothers. Examination revealed that the patient had been experiencing PTSD symptoms for several months before the onset of OCD: insomnia, intrusive recollections of the traumatic scene in the form of nightmares and flashbacks, hypervigilance with exaggerated startle responses to the slightest noise, social withdrawal, and loss of interest in sexuality. The patient reported that although the intensity and frequency of her PTSD symptoms had begun to decrease considerably after the onset of OCD, the disabling nature of the latter compelled her to seek help. Furthermore, the first weeks of treatment were marked by improvement of OCD symptoms and exacerbation of PTSD symptoms.

## DISCUSSION

From an epidemiological perspective, the risk of developing OCD is higher among patients with PTSD: men with PTSD have an 8.9-fold increased risk of developing OCD compared to individuals without such a history, and this figure reaches 9.4 for women. [4] In addition, a relationship has been noted between OCD and PTSD symptoms in some patients with this comorbidity: when OCD symptoms decrease, PTSD symptoms increase, and vice versa. Given this apparently dynamic relationship, treating OCD in isolation may hinder therapeutic effectiveness—an outcome clearly illustrated by our clinical case. [3]

From a behavioral perspective, OCD symptoms may serve to facilitate avoidance of the emotional discomfort generated by trauma. These symptoms may thus be interpreted as a protective mechanism against the (unbearable) thoughts and emotions associated with trauma. It is worth noting that OCD symptoms function as a form of adaptation rather than a substitution for PTSD symptoms. [3] Our clinical case also highlights the phenomenon of "mental contamination." In this case, the patient's fears of contamination were not truly related to germs or pollutants; rather, she seemed to feel "dirty on the inside," without any physical contact, due to "contaminants" such as nightmares, intrusive trauma-related thoughts, and/or flashbacks. Given the complexity and severity of the traumatic symptoms, a well-structured long-term therapeutic approach is likely necessary, regardless of the treatment program used.

When treating OCD with CBT, it is crucial to assess the possibility of triggering or worsening PTSD symptoms, particularly flashbacks, nightmares, sleep disturbances, hypervigilance, exaggerated startle responses, and affective or social numbing. Although the mechanisms linking PTSD and OCD remain speculative, what appears most evident is that a treatment strategy integrating the management of both OCD and PTSD symptoms simultaneously would likely be beneficial in patients whose trauma clearly preceded the onset of OCD. [3]

## CONCLUSION

OCD and PTSD share certain similarities. The remaining question is whether this relationship results from symptom overlap, a shared vulnerability, or a causal link from one disorder to the other. Conceptualizing these patients is Therefore challenging.

Several questions arise:

- Should we emphasize the importance of systematically searching for a history of trauma in patients with OCD, as has been suggested, to tailor management accordingly?
- Should these patients be considered as having two distinct diagnoses, or would they be better conceptualized as having complex PTSD?
- It would also be worthwhile to continue research to determine whether a specific form of post-traumatic OCD exists.

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