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THE GIRL WHO WOULD NOT SIT - CASE REPORT

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SUMMARY

A 21 year old girl presented with severe fear of contamination leading to 11 hours of cleaning per day and refusal to sit down anywhere except at home or in mother's car. She also had a moderate depressive episode secondary to social stressors and further isolation due to her lack of time to socialize as cleaning was her priority. She was supported according to the biopsychosocial model of care i.e. An antidepressant (Sertraline), 1:1 psychology and alternative housing away from precipitating and perpetuating stressors. She improved significantly over 6 months, but the cultural issues and stigma continued to hinder the longer-term care plans. The importance of understanding the beliefs and customs of the Travellers' community is highlighted with this case report.

Key words: *Travellers - OCD - Gipsies*

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BACKGROUND

The possible link between the cultural background and the onset of Obsessive compulsive disorder (OCD), which was triggered following traumatic events, is explored in this case report. After few appointments, it was understood that the patient belonged to the Travellers community in the area. This case brought to light the need for medical professionals to have a better understanding of the culture and beliefs of the Travellers community who have been part of our society for many decades. The trigger for the OCD was trauma related to her past two relationships. The obsession with contamination and feeling unclean was deeply entwined with her being unable to live up to the cultural expectations of the community, including being married by the age of 18 and the implications of false rumours that she was not a virgin. The resistance of Travellers to seeking medical help from 'country people' caused poor engagement and multiple missed appointments, thus making treatment more difficult than someone else with the same diagnosis.

CASE PRESENTATION

I met the patient as a 21 year old Caucasian, referred by GP for concerns of increasing social withdrawal and suicidal ideation as disclosed to her mother. She was functioning well, until about 3 years ago, when her symptoms of excessive cleaning, washing, checking started and have since got worse. She spoke minimally at the first few appointments and her mother described mental 'breakdowns' since few month. She said that the most recent one lasted 3 days, and during this time the patient mostly stayed in room and ate minimal food. She has been socially isolating herself.

She was spending 11 hours per day cleaning. This included daily emptying and cleaning of the fridge, three showers every day each lasting 1 hour, and her hands mostly being in water or holding a wet cloth. Checking behaviours and need for symmetry/order was also present. Any food packets including loaves of bread that had been opened or touched by anyone else would be thrown into the bin.

The impact of OCD was evident when she lost her job at a major retail shop for 'excessive tidying up'. She did not use public transport/toilets and would sit down only at home or in Mum's car, even if faints due to prolonged standing for hours

She ate only home-cooked food, even when they were traveling or attending functions. She said that 'I want to eat and put on weight, but there is no time to eat as there is so much to be done'. She lost all her friends as could not spend time with them as had so much cleaning to do.

She had symptoms of depression including low mood, crying spells, lack of hope for the future, anhedonia, social withdrawal and insomnia. Her mother had german measles in pregnancy and was adviced to terminate the pregnancy which she declined. However, it was a normal delivery and there were no congenital defects. There were no birth complications, learning difficulties, attachment problems or illnesses in childhood. There was no family history of OCD but her maternal uncle was suffering from depression.

There was no previous contact with metal health services, no forensic history and no history of substance misuse. There were no features of a psychotic illness. There were features of Post-traumatic stress including flashbacks and hypervigilance.

Treatment

She was agreeable to start Sertraline as it would benefit both her low mood as well as the OCD. There were problems with compliance and also few side- effects mainly gastrointestinal, which made it take longer for the change in mood. Once her mood improved, she was seen by the Psychologist who assessed and offered 1:1 therapy initially EMDR (Eye movement desensitization and reprocessing) for her past trauma which he felt had triggered the underlying fear of contamination and being unclean.

Outcome and follow-up

After 6 months, she had started sitting down at appointments, attended appointments without Mum, and planned to join College to do a beauty course with her sister. The understanding of mental health problems, how medication works and the need to attend appointments was poor. This has led to frequent missed appointments and the 1:1 psychology has had to be put on hold, similar to the problems with engagement at the beginning of the treatment period. Her engagement with the care-coordinator was also poor. However, he managed to liaise with the local Council to arrange alternative housing away from the Travellers community. This helped the patient significantly as reported by her, for a few months, until they started having threats from the Travellers community for moving out from the site, which appears to be an unacceptable thing to do within their community.

DISCUSSION

The Travellers follow certain customs with regard to cleanliness and washing, which is particularly interesting with the nature of the OCD symptoms in this patient. These customs apparently originate from Hindu purity laws. Childbirth and death are considered impure for certain number of days since the event. The lower body and genitals are considered impure and hence the clothes for the lower body are washed separately. They also have customs relating to animals e.g. horses and cats are considered to have different purity based on whether they lick their backside or not. In this particular case, the early age at marriage and virginity being an essential quality for the bride seemed to have been key stressors that triggered the OCD after the traumatic events relating to the false rumours. The rumours then spread within the Community and she was overcome by a sense of loss of control and felt ostracized by the entire Community. In the midst of her desperate attempts to regain control of her life, she emerged with a severe Obsessive compulsive disorder.

There appears to be poor understanding amongst the medical professionals about the customs and beliefs of the Gypsy, Roma and Traveller communities [www.canterbury.gov.uk/, en.wikipedia.org/wiki/Romani_people, grthm.natt.org.uk]. They constitute the largest ethnic minority within the UK with a population of about 300,000 people. Although they are protected under the Race Relations (Amendment) Act of 2000, they are subject to many kinds of discrimination. This, along with their own resistance to seek medical help from non-Traveller medical it more difficult to detect treatable mental illnesses such as the case described. History shows that they have been discriminated for centuries, including mass killings during the Nazi regime. It was interesting to learn that the Roma refer to the people that migrated from north-west India to Europe. The term Gypsy came to be used when these people were mistaken to have come from Egypt (and hence Gypsy from Egyptian). Although we have come a long way in our understanding about the Travellers, we still have a much longer way to go.

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Conflict of interest: None to declare.

References

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