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Psychotherapeutic Management of Obsessive-Compulsive Disorder with Exposure and Response Prevention and Cognitive Therapy: A Case Study

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Abstract

Obsessive-compulsive disorder (OCD) is characterized by recurrent, unwanted, distressing thoughts and resulted compulsive behavior. The management of obsessive-Compulsive disorder was the aim of this study. This was a case of a 23-year-old girl with chief complaints of intrusive thoughts of dead-bodies and the fear that thought of dead-body would contaminate everything around like foods, things etc.; repetitive handwashing, cleaning house, dressing-undressing, braiding hairs, taking showers many times a day for long hours, eating less due to fear of contamination and crossing same place repetitively. Y-BOCS, Cognitive Distortion Scale, Hamilton Anxiety Inventory and Beck Depression Inventory was administered before and after the therapy. Exposure & response prevention and cognitive therapy was used for the management purpose. Marked improvement was seen in the patient regarding her obsession and compulsions. Exposure & response prevention and cognitive therapy was successful in alleviating the symptoms of OCD.

Keywords: Obsessive compulsive disorder, exposure and response prevention, cognitive therapy, Y-BOCS.

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INTROCUCTION

We all experience intrusive thoughts at some point of our life which is perfectly okay. Having intrusive thoughts once in a while is not a big deal as it happens occasionally with everyone. But when such intrusive thoughts become repetitive and distressful in nature, that is something to be worried about. According to American Psychiatric Association (2013) when such intrusive thoughts becomes repetitive in nature and produces significant distress and anxiety in the sufferer which further foster the urge to perform repetitive and deliberate rituals, that becomes liable to the diagnosis of obsessive and compulsive disorder. Such rituals aim at neutralizing the distress and anxiety. Compulsive acts tend to provide immediate relief in the anxiety felt by patients suffering from OCD. The immediate relief provided by compulsive acts helps in reinforcing the compulsive acts. Obsessive compulsive disorder has been the fourth commonest mental disorder. It may cause disability too in severe cases (Khanna & Reddy, 2004). Kessler et. al (2005) found that OCD causes significant distress and functional impairment in 2-3% of the population who have OCD at some point in their life time. Baxter, Scott, Ferrari and Whiteford (2014) found OCD to be the most debilitating mental illness. Traditional theories like psychodynamic psychotherapy, medicines or available behavioral interventions such as systematic desensitization or aversion therapy did not produce any significant positive therapeutic result for OCD. Hence, OCD was thought to be untreatable. (Foa, Yadin & Lichner, 2012). Later in 1966, Mayer came up with a breakthrough in the treatment history of OCD. Mayer had used prolonged exposure to the distressful object or situation and strict prevention from doing compulsive rituals to get rid of the anxiety. Mayer's finding was supported by subsequent studies. Exposure and response prevention treatment was found to successful in treating OCD. Patients reported significant relief from this treatment. Exposure and

response prevention treatment was successful in hospital setting as well as in outpatient setting. Patients reported that the maintenance of the improvement made by exposure and response prevention treatment stayed for many up to two years post-treatment(Foa & Goldstein, 1978; Foa & McLean, 2016; Marks, Hodgon & Rachman, 1975).

CASE REPORT

The index patient, Ms. R, 23-year old, female, Hindu, Hindi speaking, educated up to B.com(graduate), unmarried, unemployed, hailing from the semi urban area of Jharkhand, belonging to middle socio-economic status was brought to the hospital (RINPAS) with chief complaints of intrusive thoughts of dead-bodies and the fear that thought of dead-body would contaminate everything around like foods, things etc.; repetitive handwashing, cleaning house, dressing-undressing, braiding hairs, taking showers many times a day for long hours, eating less due to fear of contamination and crossing same place repetitively. The patient had these problems for last two years. The patient's illness started with an incident of death in her neighborhood. This incident was quite distressing to the patient and the ideas of death and dead bodies started coming to her mind. This scared her. She was very attached to her family, so ideas of death got associated to the death of the family's members. These ideas became too frequent and she felt distress due to these intrusive ideas. She started thinking that when she touches something or does any work the dead body will stick to the things and contaminate it. If this happens then in reality her family member may die. To avoid this to happen she started doing the same task several times until she was satisfied that nothing will happen to her family members. She ate very less food because she thought that it is contaminated by being in contact with dead bodies. She used to dress and then undress several times as she thought clothes were also getting contaminated. She became overly conscious about cleanliness and was not satisfied even when

she cleaned the house herself. So, she would repeat cleanliness routine several times. She had developed a habit of crossing the same place and doing the same thing again and again until her worry and anxiety subsided. She would braid her hairs several times due to the fear that dead bodies are getting into the contact with her hairs and making her hairs contaminated. She would repeat cleaning of utensils and making food several times. Gradually, she started avoiding all the work due to the fear of contamination. The patient was under pharmacological treatment for one and half year and her symptoms improved to the extent that she was able to perform her works to a great degree. The patient had stopped her medication five and half months before coming for the current consultation. She had a relapse of her symptoms. Her symptoms had become even more intense this time.

Rationale for choosing the Exposure & Response prevention (ERP) and Cognitive Therapy as treatment of choice for the present case.

It was found that pharmacotherapy had affected the obsessive and compulsive symptoms in the patient to a great degree but the fast relapse after the discontinuation of the medication indicated that medication had somehow suppressed the symptoms to a degree but no changes at cognitive level had been observed as the patient had not learned in a long duration of treatment with medication that the anxiety and fear she was feeling had no roots in reality. She had lost all of her control over the situation and only wished someone would save her from all those distresses. The interview with the patient indicated that she had not understood her illness well. She had insight that it was all her thoughts which were distressing her. But still she had no insight how she was contributing in the maintenance of the illness. The fast relapse suggested that the patient needed to participate actively in her treatment. So, it was decided that exposure and response prevention therapy would help her regain her lost control over the situations by

subsiding associated intense anxiety. Besides, exposure and response prevention has been found to be the most successful therapy for obsessive and compulsive disorder. The patient was found to be engaged in faulty thinking. Such faulty thinking contributes in the origin and maintenance of mental disorders (Beck, 2011; Beck & Clark, 2010). Cognitive therapy was also used for her treatment as there were many faulty thinking patterns which contributed in her illness.

Measures:

Following assessment tools were used before and after the therapy.

- **Yale Brown Obsessive Compulsive Disorder Scale (Y-BOCS):**The Yale-Brown Obsessive-Compulsive Scale (Y-BOCS; Goodman, Price, Rasmussen, Mazure, Delgado, et al., 1989). YBOCS is acknowledged as the gold standard measure of obsessive-compulsive disorder (OCD) symptom severity.
- **Cognitive Distortion Scale:** The Cognitive Distortions Scale (Briere, 2000) is a 40-item test that measures five types of cognitive distortions Self-Criticism, Self-Blame, Help-lessness, Hopelessness, and Preoccupation with Danger.
- **Beck depression Inventory**: Beck depression inventory (Beck, Steer & Brown, 1996) was used to assess the severity of depression. It is a 21-item inventory.
- **Hamilton anxiety inventory:** Hamilton Anxiety Inventory (Hamilton, 1959) was used to the assessment of the anxiety.

Therapeutic intervention

Patient and the patient's family was explained about the obsessive and compulsive disorder. Later, they were explained about the exposure and response prevention and cognitive

therapy. A detailed therapeutic plan was prepared in collaboration with the patient. Subjective unit of distress scale was prepared regarding different situation provoking the anxiety in the patient leading to the compulsive acts. Considering the inability of the patient to come for the therapy session on regular basis each week, family was included in the management plan as a medium to provide essential administrative environment for the exposure and response prevention in real life situations. The patient's brother was explained about the exposure and response prevention and was instructed about the procedure so that he would be able to conduct exposure and response prevention home work session at home in real life situations. It was kind of a home-work for the patient which family had agreed upon providing their full support. Twelve sessions of exposure and response prevention were conducted over a period of three months. Each session lasted for 70-110 minutes depending upon the comfort of the patient for her availability for the session as she used to come from a different district. The patient was doing her home-work for exposure and response prevention in vivo at home in between the session. Telephonic assistance was provided to the family and the patient regarding the home work session at home whenever any kind of doubt arose. Each session with the patient included cognitive strategies at the end of the ERP session to deal with the cognitive errors in the patients which were contributing in her illness. The patient was very attached to her family and intrusive thoughts of dead bodies followed by fear of the death of family members suggested how intensely she was interpreting the situations as dangerous one. The patient was using catastrophizing too frequently. Self-blame was the other cognitive distortion which the patient was using and which contributed significantly in the maintenance of her illness as she took it as her responsibility to stop the mis-happening by doing compulsive acts. The patient had an inflated sense of responsibility. The patient distorted belief that she has somehow got the sole

power of controlling mis-happening in her life and to her family. The patient had started giving the too much attention to her intrusive thoughts and tried every ritual possible to get away with the obsessional ideas of dead body. It was explained to the patient by using camel effect that how putting in extra effort to get rid of any thought actually makes its rebound occurrence more frequently. This helped the patient a lot for understanding about the occurrence of thought and their persistence in consciousness stream due to underlined factors like appraisal of a specific thought or idea as being important for the subjective reasons. It also taught the patient about one's inability to have intentional control on one's unwanted thoughts. Pie chart method was used to break into the patient's distorted belief of inflated responsibility. This method worked best for the patient in letting her convert her belief in the presence of appraisal of other contributing factors for the occurrence of any unwanted event. It was discussed with the patient that what could be the probable reasons of an actual demise of any person whether an outsider or a family member. It was discussed with her that what are the other factors which can lead to a dangerous illness or demise in the family members. The patient came up with multiple factors like, physical illness, accidents, etc. The patient was guided into her obsession and compulsive acts that how blindly she executes her compulsion not to ensure the safety of the family but to get rid of the obsessional idea, as she never had been worried about the physical illness and accidents of family members. Cost-benefit analysis of the amount of time spent in controlling the obsession helped her access her experimental attitude for watching out forthcoming outcome. As the exposure and response prevention sessions were conducted simultaneously, it helped the patient a lot in gaining her lost control over situation and tackling the anxiety. The patient was on medication during the whole psychotherapeutic management.

RESULTS

The patient's obsession and compulsion improved as the same was indicated by the scores on YBOCS, Cognitive Distortion Scale, Hamilton Anxiety Scale and Beck Depression Inventory. Pretreatment scores on YBOCS were 16 and 15, respectively on obsession and compulsion severity with a total of 31 indicating severe range of obsessive-compulsive symptoms in the patient. Pre management scores on cognitive distortion scale showed high T scores on self-blame (70), helplessness (68) and preoccupation with danger (72). Pretreatment score on HAM-A was 32 and 21 on Beck depression inventory suggesting severe level of anxiety and moderate level of depression in the patient before the treatment. Post treatment scores on YBOCS were 9 and 6, respectively on obsession and compulsion severity with a total of 15 indicated mild level of obsessive-compulsive symptoms. Post treatment scores on cognitive distortion scale were, self-blame (58), helplessness (49) and preoccupation with danger (55). Scores on HAM-A and Beck depression inventory were 14 and 11 suggesting mild level of anxiety and minimal range of severity of depressive symptoms.

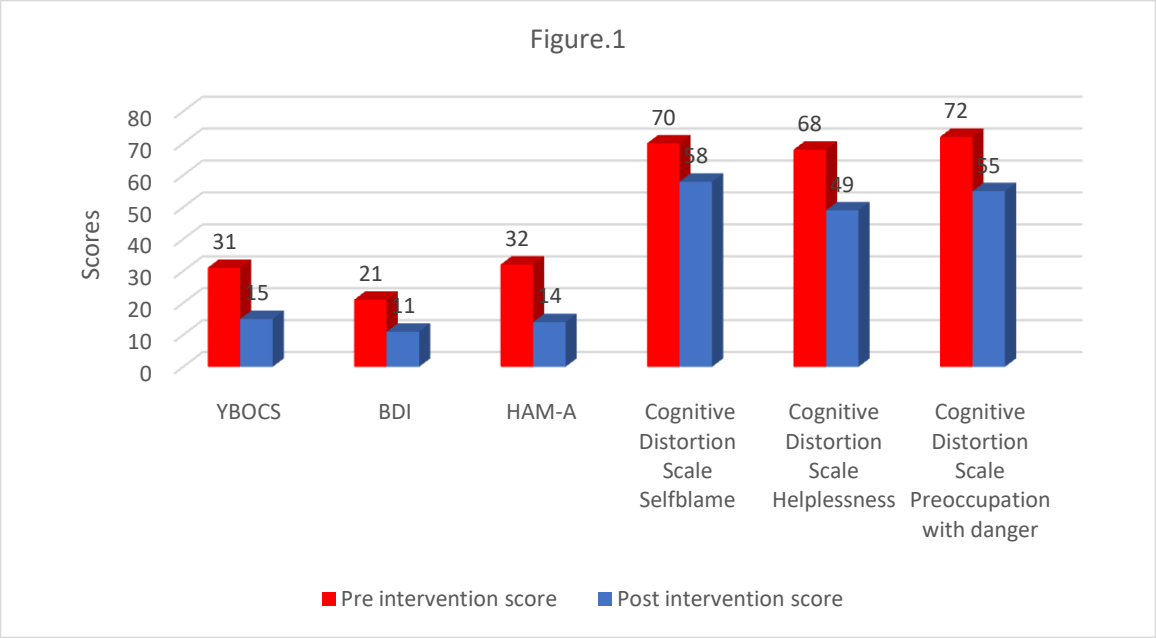

Figure 1. Showing the value on different measures the indexed patient scored pre and post the ERP and Cognitive therapy.

DISCUSSION

The purpose of this study was to plan and administer a psychotherapeutic management package as per the need of the patient and the availability of resources for the proper execution of the therapy. Exposure and response prevention along with cognitive strategies proved to be very helpful in alleviating the obsessive and compulsive symptoms of the patient. Inclusion of the family's active support in facilitating the proper exposure and response prevention between the sessions proved to be very helpful. It was not convenient for the patient to come for the session on regular basis. Hence, the patient took session 12 sessions over a period of two months as per her convenience. Family was very prompt in delivering the regular homework ERP at home. The guidance provided telephonically proved to be very helpful in clarifying any doubt arose between the sessions and helped the patient in sticking to her homework ERP.

CONCLUSION

There are studies which found that exposure and response prevention (ERP) is more effective than other available psychotherapeutic treatments ((Lindsay, Crino, & Andrews, 1997). Foa et.al (2005) conducted a placebo-controlled trial to compare the effectiveness of exposure and response prevention (ERP) to combination of ERP and clomipramine and only clomipramine each for 12 weeks. The result showed no difference between result produced by ERP and combination of ERP and clomipramine. Both the ERP and combination of ERP and clomipramine was found to be superior than only clomipramine. There is substantial evidence which supports CBT to be first line treatment for OCD. Olatunji, Davis, Powers and Smits (2013) found large effect for CBT in comparison with other controlled treatments in a meta analytic study at post-treatment level and moderate effect at follow-up. ERP is a highly efficacious treatment for many people who suffer from OCD (Hezel & Simpson, 2019). The present case study also found exposure and response prevention along with cognitive strategies as a successful treatment for obsessive-compulsive disorder.

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