PROCESS OF PSYCHOLOGICAL INTERVENTION IN CHRONIC OBSESSIVE COMPULSIVE DISORDER

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PRESENTING COMPLAINTS

- Repeated thoughts and fear related to contamination and disgust associated with waste and every material that comes from outside.
- Repeated washing of hands and other objects especially that comes from outside (bread packs, vegetables, locks, door knobs and other) from 3 different soaps 2-3 times.

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CASE SUMMARY

50 year old married Hindu female from MSES, educated up to SSLC with no family history of any psychiatry illness, however she reported that as she is from a Brahmin family maintaining cleanliness was strictly followed.

Presented with complaints of repeated thoughts concerned with things not being clean and fear associated of getting contaminated due to same, she reported that for the whole day she is worried about getting contaminated and thus takes almost the whole day to perform her daily routine work (bathing brushing, washing cloths and toileting). She reported that since morning after all her family members leave home and she is left alone; she stands outside the bathroom areas preparing herself to get inside but is not able to do so, because of the fear of getting contaminated and a disgust feeling associated with it, and she has to be pushed to do all this after her family members return from their work in evening. After that she needs at least 7 hours to complete all her daily activity, she told that she takes almost 25- 30 minutes to brush as she is not able to let go the feeling that it's not clean and go on brushing until she gets feeling of being clean she reported that the feeling of being clean comes all of a sudden is not associated with any special number or concept. She reported of taking 2-3 hours to take bath, and at least 3 hours in toilet; she reported that after going to toilet she need to wash herself at least 3 time with different soaps (dettol or any other antiseptic soap) in a ritualistic manner, she 1st washes her feet then legs then palm then hand followed by washing her complete body; it's almost like taking bath; she reported of following the same ritual at night also if she gets up for toilet.

She reported that she gets an urge to clean all the objects that comes from outside again associated with fear of getting contaminated, thus she cleans everything including packed items (biscuits pack, bread pack vegetables, slippers, and other objects also) from soap at least 2- 3 times with 3 different kind of soap until she gets a feeling that its clean, she also reported of fear associated with touching bed sheet, curtains at home, T.V, T.V remote, mobile phone as she gets an urge to wash herself completely if she touches these objects. She also reported fear related with something going wrong or going out of control and thus reported of repeated checking of door locks, gas knobs, turning back and checking her own footsteps while she is walking. She also reported of keeping 3 different soaps at 3 different places to ensure purity and cleanliness, she even reported of spitting after seeing and hearing something dirty (toilet seats, dirty toilet,

pits on roads, garbage can, and also seeing people from *other religion* (Muslim religion and women wearing Bhurka) and acute distress associated with inability to spit. She told that in instances where she cannot spit she collects it in her mouth and spit it as soon as she gets opportunity to do so. She also told she ask her family members to also to follow certain rituals as cleaning feet every time they come from outside 3-4 times or even more, make them also wash objects that is bought from outside else she fights with them and continue being in irritable mood until her wish is fulfilled. She reported that she completely avoids such situations and try walking in a restrictive pattern so that she do not come in contact with objects (toilet doors, pits and other) she also avoids getting out from home and thus stay in home in order to save herself from feeling distressed and irritated and also feel safe. She reported that she is maintain these habits as they are good and keep her and family members healthy and thus do not report of any problem associated with these rituals. She reported that her reason to come for treatment is her family members especially daughter and son who think that she has a disorder of excessive cleaning and it's not good as it disturbs their daily routine and life and also her son marriage proposal and her worry about a new member been added to her family and adjustment with her.

Daughter corroborated with her report and she added that she has completely stopped doing any household work, has made herself completely home bound, do not attend any social event and also has had strained relationship with extended family mothers and her father also. She reported that for all these year she was never treated for her symptoms as her father never took care for these symptom he just started doing things for himself on his own, started eating out until she got old enough to cook, he also stopped depending on her mother for any kind of help and almost abandoned her for her problems, she reported that her father is very caring towards brother and her but she have no idea why he never took care for mother and showed it to doctor.

She reported that her brother and she thought of getting her treated as they could see that all this was not normal and when she started reading medicine and discussing about her mother to her other doctor friends they got to know that it could be OCD(obsessive compulsive disorder) it was then for the 1st time in year 2010 they showed her mother to a psychiatrist but the treatment was not successful because of the stigma associated with psychiatry medicine and patient in their culture and society and thus she decided to bring her mother to XXX hospital so that she can stay with her while she will complete her course and take regular treatment. She also reported that her

mother understands now that she has some problem but she is not completely agreed and motivated for treatment.

PREMORBID PERSONALITY

According to the patient she has always been anxious by nature. She preferred company but only with people he is familiar with. Daughter described her mother to have low frustration tolerance, very dominating and also and rigid.

ASSESSMENT

Yale Brown Obsessive Compulsive Checklist and Scale

On YBOCS the following obsessions were elicited. Obsessions of contamination and other obsession for spitting after seeing from other religion present but was not associated with magical thinking and compulsion of cleaning, washing and Checking were present. The obsession subtotal score was 18 and the compulsion subtotal score was 13. The overall global severity score **was 4** indicating moderate- severe symptoms with limited functioning. With avoidance score of **4** extreme- very extensive avoidance; patient do almost everything she can to avoid triggering symptoms.

Cognitive Behavioral Analysis:

A**.** Brief Description of problem:

- Repeated thoughts about contamination, feeling of disgust
- Compulsion of repeated cleaning, washing and checking.

- Time course:
    - 25 years, illness started when she was 24 year old, course of illness being continuous and detoriating.

- Precipitating Factors:
    - Illness started when she moved to her husband house after marriage, she had interpersonal problem with her husband and in – laws corresponding to which she also developed excess responsibility of keeping her home clean considering responsibility for every bodies health and thus she started cleaning objects which came from outside but later the problem spread to other areas.

- Predisposing factors:
    - Personality traits (anxious, dominating and rigid)
    - Family practice of maintaining excessive cleanliness and ritualistic practice since her childhood.

B. Problem Behavior:

- Behavioral:
    - Avoidance of doing any house chores work (cooking, washing and dusting)
    - Avoidance to moving out of home constricted her within home and completely home bound.
    - Collecting saliva and spitting saliva if seen any object that is dirty and also if she see individual from other religion.
    - Repeated washing, cleaning and checking to neutralize the effect of thoughts.

- Cognitive:
    - Repeated thoughts that things are not cleaned properly, things are not pure and also thoughts regarding her not being clean and pure.

- She has feeling of something going wrong or out of control if she does not follow these compulsions.

- Affective:

  - Experiences anxiety, fear and distress when she has not repeatedly washed, cleaned or checked for objects or things for which she had doubts or thought of not being clean.

  - Patient reported that these thoughts occur every day and was unable to tell the specific time when it occurs.

C. Context and modulating variables:

- Situational:

  - When she has to do any household work if daughter is not well.
  - When she has to perform her daily routine activity.
  - When she has to move out of home for any reason.
  - If come across individual from other religion.

- Cognitive:

  - When she worried about getting illness or harming herself and getting contaminated.

- Affective:

  - When she is more tensed or irritated from any reason.

- Interpersonal:

  - When interacting with people and not among her family members.

D. Maintaining Factors:

- Behavioral:
    - Avoidance of social and interpersonal situations.
    - Avoiding coming in contact with object consider to be dirty and people from other religion.
    - Repeated washing, cleaning and checking and neutralizing behavior checking,

  washing and cleaning for anxiety reduction.
    - Repeated reassurance seeking.
- Cognitive:
    - Her feeling excessive responsible for herself and her family members health and excess concern with purity.

E. Avoidance:

- Avoidance of social and interpersonal situations and also avoiding coming in contact with object considered being dirty and people from other religion.

F. Coping:

- Poor coping: her coping strategies are maladaptive. Copes only by avoiding

  situations or going out and performance of neutralizing activities.

H. Mood/Mental State:

- She reported of feeling anxious, fearful and upset most of the time.

I. Psychosocial situation:

Patient has a poor support from family consisting of husband and her in-laws; her Son and Daughter were very supportive and daughter is the only one in family who kept her motivated for the treatment and take complete care. Currently she has no support from friends and religious community.

THERAPEUTIC FORMULATION

50 year old married Hindu Female with anxious, low frustration tolerance, rigid and dominating trait presented with history of obsession of contamination and other obsession for spitting after seeing people from other religion which resulted in compulsion of washing, checking and repeating rituals since past 25 years accompanied by significant distress, neutralizing and avoiding behavior. Precipitating factors were the interpersonal problems with husband and in – laws after her marriage, Predisposing factors were her personality factors (anxiety, low frustration tolerance, dominating and rigid traits) also her maternal family belief system and rigid practice of rituals and cleanliness. Maintaining factors for her illness are family negligence towards her illness, poor family support also her neutralizing, repeated reassurance seeking, repeated checking and avoidance behavior. Protective factor for her illness is her current motivational level due to her son marriage proposal and her worry about a new member been added to her family and adjustment with her; also her daughters constant interest and motivation to help client come out of her illness.

WORKING DIAGNOSIS

- Obsessive Compulsive Disorder (mixed type)
- F42.2 No F/h/o mental & behavioral disorders

RATIONALE FOR INTERVENTION:

In the history patient has mostly reported of high distress associated with the current situation and thus ERP was considered the first line of treatment to make her more tolerant to the distress; and also a meta-analytic reviews have reported that exposure with response prevention (E/RP) and Cognitive Therapy (CT) was significantly more effective than relaxation (RLX) training. Thus Cognitive behavioral approach was taken to treat patient**.**

THERAPY PLAN

Short – term goals:

- Psycho educates patient and family
- Reduce symptoms and distress level
- Reduction of avoidance

Long-term goals:

- Addressing interpersonal issues
- Relapse Prevention

ACCOUNT OF THERAPY:

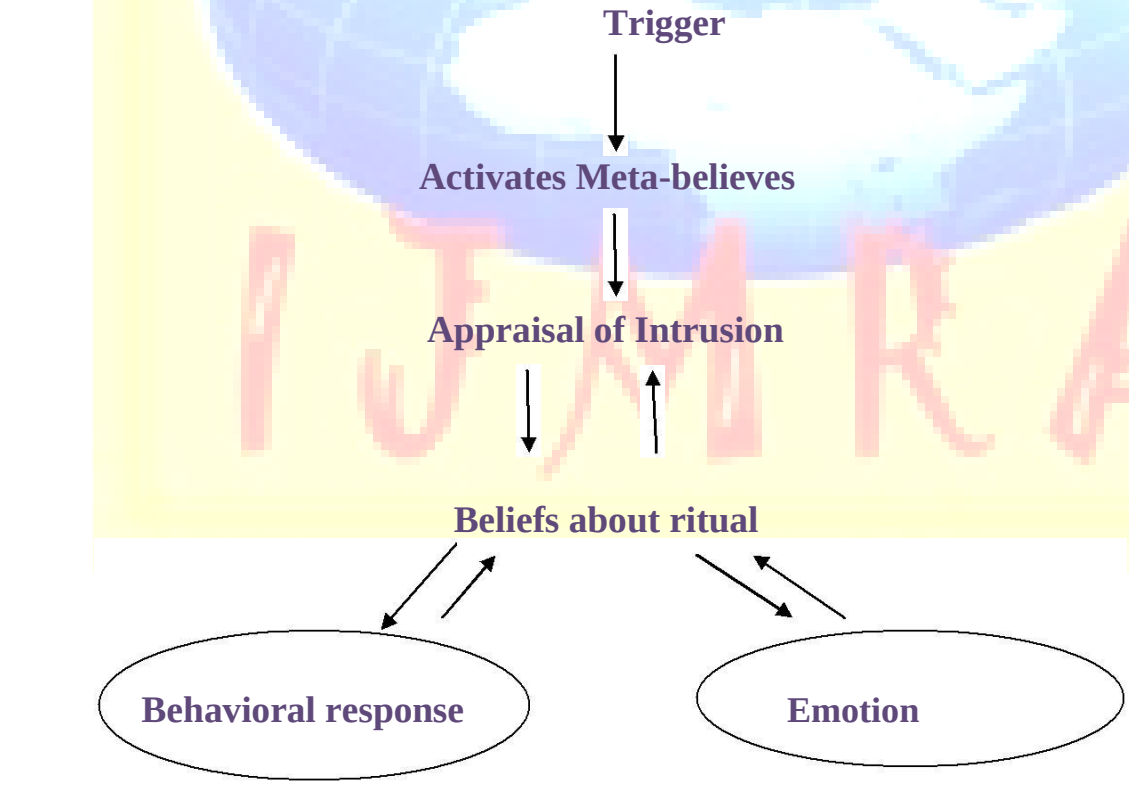
35 sessions of ERP and Cognitive restructuring was done, treatment plan was divided into initial phase of treatment (session 1- 7) where psycho educating the patient about her symptoms, behavioral experiment to explain her how neutralizing behavior maintain the symptom and psycho education of family were the central goal. The middle phase of the treatment (8 – 34) where regular ERP sessions for one hour on a daily basis followed by cognitive restructuring and treatment was ended all of a sudden and after which it discontinued due to patients mother's suddendeath.

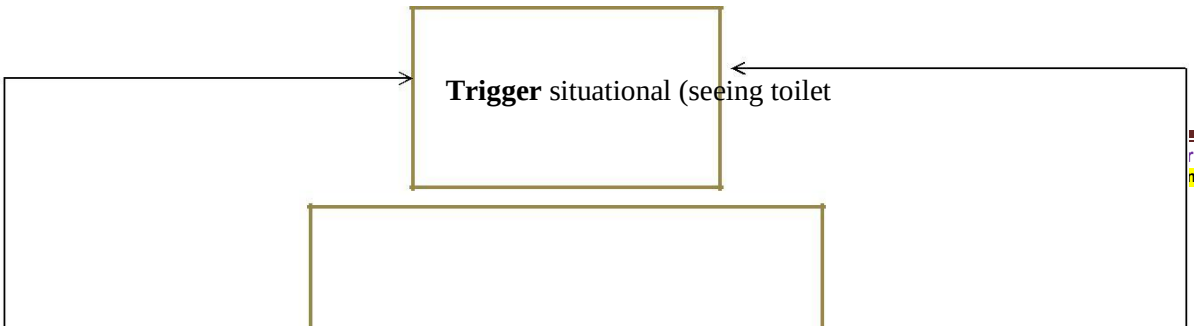
In the **initial 2 session's** detailed history of the patient's complaints was taken from patient and family members; daughter and husband.

In the **3rd session** Y-BOCS was administered and cognitive behavior analysis was done.

In 4th session patient and family member; daughter and husband was psycho- educated about the illness, its symptoms, prevalence and course. They were explained the biological model emphasizing the role of brain structures and neurotransmitters and how medication helps in the management of OCD.

In 5th session patient was socialized to the cognitive model of OCD and it was explained. The role of neutralizing behavior in the maintenance of the symptoms was illustrated.





seat) intrusion: it's dirty)

Activates meta- beliefs (Fear of contamination, purity, Religiosity)

Appraisal of intrusion Belief about rituals (If I don't perform my rituals my feeling will never end)

Behavioral response

(Suppressing

thoughts, repeated

washing., checking)

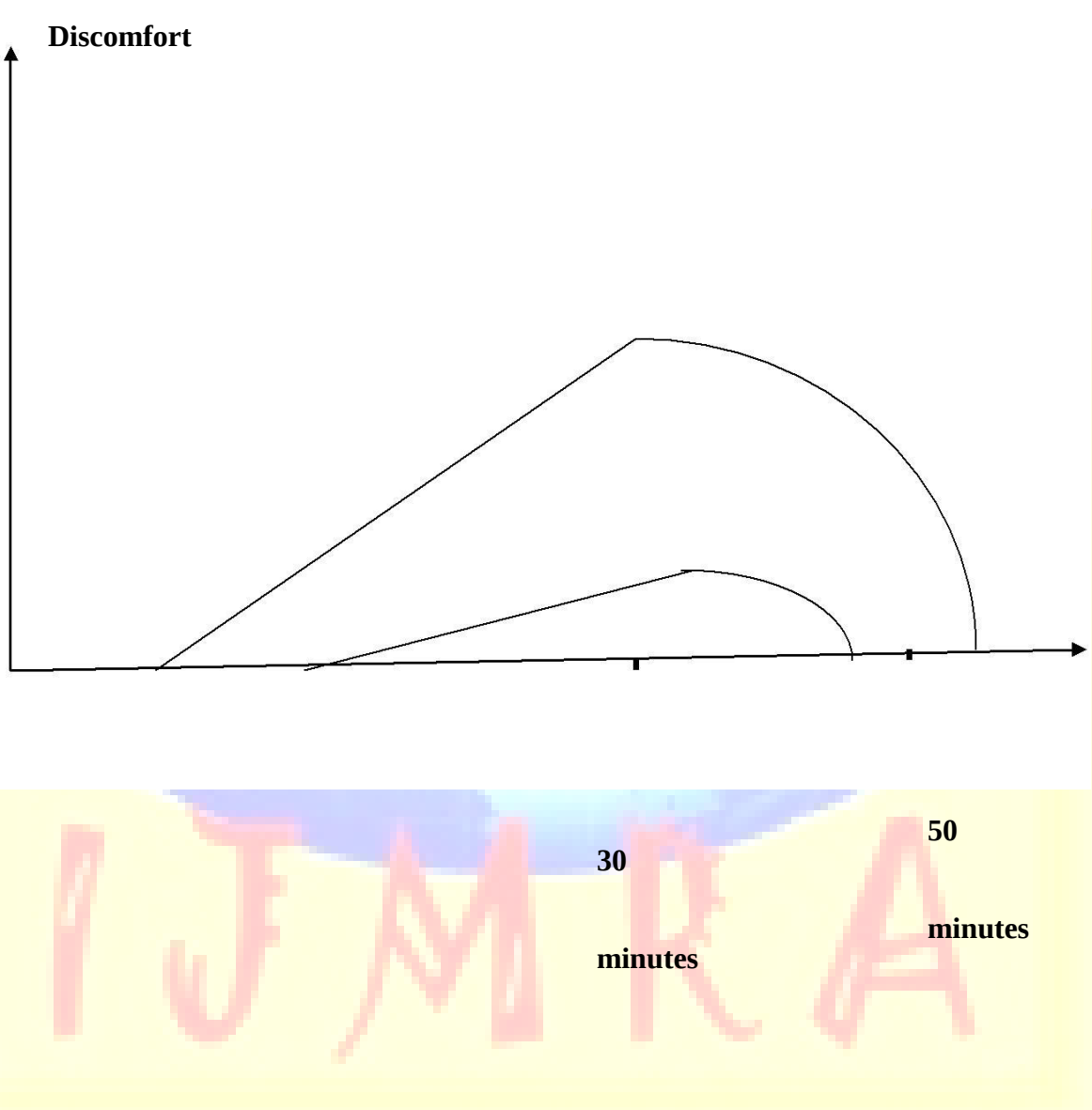
Emotions

(Anxiety, distress)

General working: Cognitive model of OCD

In 6th and 7th session rationale for Exposure and Response Prevention Therapy was explained. She was explained that initially there will be significant rise in anxiety, discomfort and urge to neutralize. Rather than continue to get worse this rise remained quite steady then gradually decreased so that by the end of the session the level of discomfort almost return to normal.

To explain this better she was asked to imagine the image of a dirty toilet with shit and it being all stained. She reported 50% anxiety. When this image comes, she would either get up from that place, or shake her head and disgust and distress could be easily seen on her face. She was asked not to do any mental compulsion or not to nullify the effect by doing any neutralizing act and she was asked to continue imagining the imagine until her distress reduced and she felt much calm and relaxed; after 30 minutes she reported her distress coming down and completely subsiding after 50 minutes. Thus through this small example she was explained that how doing so, her anxiety significantly decrease. Hence she was shown how these compulsive behaviors would be increasing the anxiety related to the obsessive thought.



Session 8th before starting ERP session a hierarchy was constructed based on the distress levels starting with the lowest to the highest.

	Hierarchy for ERP Therapy	Anxiety (%)	No. of sessions
1.	Not wiping down goods bought from outside	10	5
2.	Touching mobile and T.V remote	20	7
3.	Touching object(bed sheet, door knob, windows) eating without washing.	50	15
4.	Not allowed to spit after seeing dirty object and Muslims	70	Side by
5.	Using western toilet at home and public place.	90	35 (initiated after 5th session till end)
6.	Not being able to wash feet-hands-face- body after urinating.	90	------- -------
7.	Touching, seeing or talking to individuals of other religion , and then eating without performing ritual.	100	

The patient was found to have 100% distress associated with touching, seeing or talking to individual of other religion and then eating without performing rituals; and 10% distress associated with not able to wash things bought from outside based on the SDUS. Also timing for daily activity was also made for initiating home work session initially all sessions were conducted in daughter presence and she was taken as a co- therapist to monitor change at home for treatment being more effective from **8th session till 34th session**

TIME SCHEDLING FOR DAILY

ACTIVITY: Brushing 20 – 30 minutes

Toilet 3 hours

Bathing 2 hour

Followed by Rituals (of 1st washing her feet then legs then palm then hand followed by washing her complete body)

According to hierarchy made and the detail collected about her daily activity – graded exposure was initiated – at home and therapeutic setup.

Initial session of all in – vivo exposure started with 2 min of exposure to triggering stimuli (touching curtains, bed sheet, and exposed to toilet) gradually time and task difficulty level was increased (initially when therapy was initiated therapist exposed client to the target stimuli for 2 min, with report of decrease in client's anxiety time for exposure was increased to 5 minutes then to 15 and finally to 20 minutes)

Similar step was followed at home setting; where daughter was asked to keep only one soap in bathroom, to keep mobile in bathroom when client goes to take bath and toilet; and set alarm at gap of 30 minutes (so as to note time taken and see if improvement was there or not) and client was also motivated to reduce her rituals; and during each sessions graphs were constructed to show how distress reduces completely even without performing any rituals or neutralizing act; cognitive restructuring of her feeling excessively responsible for the safety and health of family members were also targeted during alternative sessions where she was explained hoe not maintain rituals are not affecting any family members health specially as daughter was staying

with her mostly she was taken as an example to explain and restructure her thought process. Regular Exposure to toilet and touching of bed sheet and cleaning of sofa set were continued at home too.

Each exposure session was followed by making client eat something from her hand, to prevent compulsions or any other neutralizing act and in order to complete the exposure procedure. At home daughter was also asked to follow the same.

Repeatedly she use to report feeling of disgust and distress; thus cognitive restructuring was done to reduce such cognition too. However client's belief regarding other religion individual's could not he handled as it had a strong cultural value and family belief system associated to it. Thus dealing with such cognition was kept as a long term therapy goal.

During session's client reported of excess anxiety with further increased time of exposure (30 minutes); so in order to reduce client's distress and resistance and facilitate exposure task

(Looking at the toilet)

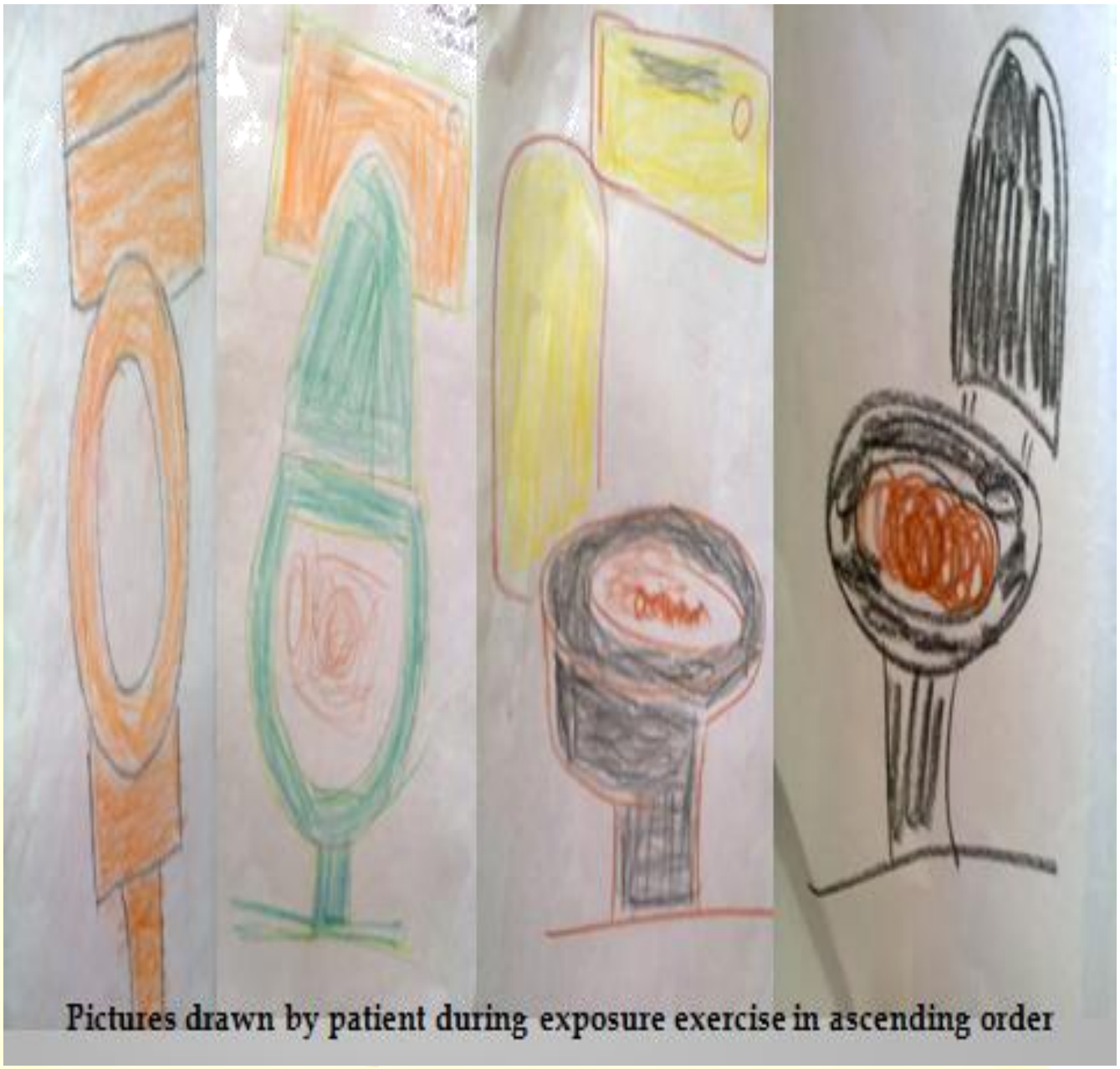
Therapist planned for Exposing client to pictures of toilet on laptop screen - anxiety reported was 90% due to the cognition that it is similar to touching toilet. Seeing was still ok according to her but getting the feeling of touching was even equally disgusting.

Thus again hierarchy construction was done to facilitate the single task

Hierarchy for ERP Therapy	Anxiety (%)	No. of sessions
1. Drawing the diagram of western toilet	10	Begin after 18th session
2. Coloring the diagram from own hands	20	
3. Touching the diagram from hands	30	Anxiety reduced after 23rd session
As touching laptop and item related to it was higher in hierarchy , she was exposed to drawing and later slowly switched to laptop		
1. Touching laptop keyboard with the picture been displayed on the screen	70	Begin from 24th session and improvement noticed by 30th session thus in vivo exposure to toilet begin again for 30 minutes
2. Touching the sides of laptop with the picture on[pen on screen	80	
3. Touching picture of western and Indian dirty toilet on laptop screen	90	

It was decided to ask client to draw and color the same – anxiety reported was 30%.

Initially when it was started client had no difficulty drawing and coloring the diagram but when asked to touch the diagram from both the hands and then eat something to prevent compulsion she reported of 30% anxiety. After **5 session** of exposure anxiety reduced up to 5%. During the session we noticed that the early diagrams were all colored with fancy colors and there was a reluctance to go for dark and dirty colors which she founded dirty but **by 23rd session** and from the repeated exposure exercise in the therapeutic setup and home she was able to draw and color the diagrams from black, brown color and comfortably touch them with little hesitance to eat after that but she always use to manage it with little motivation.



Pictures drawn by patient during exposure exercise in ascending order

Thus initiated - touching picture on laptop screen from **24th session**; initially she was resistant but with motivation she started touching sides of laptop screen with image of toilet on it.

Then through sessions she started touching the ground area in the image, then the walls and slowly could touch the whole picture by **30th session** except the center where toilet seat was drawn. **By 32nd session** in vivo exposure to toilet for 30 minutes was initiated and she was able

to complete session completely but with lot of motivation and struggle.

Same exposure was carried at home setting by her daughter. Thus improvement shown was even faster.

By side these exposure task given to her at the therapeutic setup she was constantly managed and taken care for her ritualistic behavior patter related to her daily activity and that was done every day at home by her daughter and was followed up by the therapist every alternative day.

Therapy was going on very well and as improvement in symptoms were shown we planned to go even higher in hierarchy and initially begin with cognitive restructuring of her though process related to individuals from other caste then start in- vivo exposure for same as these beliefs were culturally influenced .

But the therapy was **terminated due** to sudden death of patient's mother for which she moved to her home town for a month, after which she returned for psychiatry follow up and psychology follow up also. As the therapy had to be terminated before expected time we were not able to have complete planned session of relapse prevention. Still before terminating therapy one session for relapse prevention was conducted in which the patient was explained error in thinking as need for certainty, excess responsibility, and perfectionism or over estimation of risk. She was explained how some of the experiences that are part of OCD such as intrusive upsetting thoughts are bound to occur, and thus she should also make plans to deal with them with help of family members or others and not be taken by surprise or make the cognitive error of absolute thinking. She was explained that when a person is under pressure or feels stressed everyone is likely to experience an increase in intrusive thoughts and if she understands this she can effectively deal with her anxiety as she will be able to understand that these are faulty thought process and cognitions that are part of illness and if not followed may cause anxiety but are not harmful thus she should not think it represents some sort of failure or they are back to the absolute thinking and thus she was asked to identify such situations and follow the practice of exposure and not follow the thoughts as they are error in thought and cognition. Daughter was also a part of relapse prevention as currently she was primary care taker.

OUTCOME OF THE THERAPY

1. On reviewing at the 25th session it was found that her time taken for brushing came down from **20 minutes to 5 minutes**
2. Her bathing time came reduced to **one hour a day** from 2 – 3 hours
3. Her toilet timings also reduced from 3 hour to **2 hour**
4. She was able to complete her daily activity **in 4 hours rather than** sitting for the whole day or taking 7 – 8 hours to complete it and she was also able to manage her behavior by self, and not much depended on her daughter for everything.

On assessing it was also found that with therapy clients repetition came down (*washing hands 3 times with 3 different soaps, washing every object that came from outside, washing feet, hands, body each time see a toilet and spitting 3 times if see dirty object or people from different religion*) **Completely stopped.**

She stopped compelling others also to wash their feet every time they use to come from outside, completely stopped wiping objects that came from outside, she also started locking doors without repeated checking and use to feel comfortable to move out from home alone.

Thus along with her symptoms her social functioning also improved.

FOLLOW UP NOTES:

1st follow up: patient was from out station and therapy was **terminated due** to sudden death of patient's mother for which she moved to her home town for a month. She was called for follow up after 3 months; on her 1st follow up recovery was sustained she use to take 5 min to brush, for bathing she was taking 45 min to 1 hour, toilet rituals timing reduced; she was now taking one hour or sometimes one and half hour in completing her daily toilet routine for which she use to take 2

hours or more. She was now taking 3 hours to complete her daily routine work instead of 4 hour at time of discharge, she was also regular on medication and homework exposure exercises as during time of therapy session, still she required help from family members or cues to help her control her rituals and compulsion but reported that there was only 5 % distress associated with not able to follow compulsions.

Her mood was happy /contended and she also reported that her family was thinking about her son's marriage due to her improvement and her other social relations have also improved as now she can manage time for recreational activity like watching TV or giving time to neighbors beside her daily activity . Daughter corroborated with the information given.

2nf follow up: patient again came for follow-up in OPD after 3 months .she reported of maintain well and compliance to medication was intact. She reported that she was now taking 5 min to brush daily, for bathing and her toilet activities she was now taking 3 hours. Her daily routine activity like washing, dusting, etc she was taking 2 hours. She also reported that she was able to make new friends and had more time for recreation. She reported that her obsession related to other caste people disturbs her and during that time she gets an urge to wash her hand or spit which she tries not to but still becomes compelled sometime to do so; she was encouraged for her efforts, and was explained that as this obsession has a cultural and emotional base it will take her some time to control her compulsions related to it and thus she should continue her efforts and not get distress with failures rather encourage herself from the success that she could make each day related to these compulsions . Daughter corroborated with the information given.

3rd follow up: Patient was not able to come for follow up. Daughter reported that she was maintaining well and improvement is static. She reported that patient was adherent to medication, she also needed less assistant and cues to control her compulsions now. She also reported that her brother marriage was fixed.

After 3rd follow up as patient was out of station and maintain well she was asked to take further reference form local psychiatrist doctor and psychotherapist and report if any relapse occurs.

PROBLEMS ENCOUNTERED IN THE THERAPY

- The main problem faced was the time restraint as the session use to be only for an hour and in many initial sessions it use to take almost an hour extra to make her understand why not to follow her neutralizing act and how eating helps in completing her session; so that she finally eat. Many occasion almost 2- 3 days in a week sessions were conducted for 2 hours because of the same reason.

- Age of the patient and long duration of illness (around 25 years) affect the outcome of the therapy.