

Case Study

## Understanding Therapeutic Considerations While Using Cognitive Behavior Therapy in Obsessive Compulsive Disorder: A Case Study

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### ABSTRACT

Obsessive thoughts and compulsive urges are part of the normal feedback and control loop between our thoughts and our actions. It is only when these obsessive thoughts become so intense and frequent and these compulsive rituals become so extensive that they interfere with an individual's functioning that the diagnosis of Obsessive Compulsive Disorder (OCD) is made. The mainstays of treatment of OCD includes Serotonergic antidepressant medications, particular forms of Behavior Therapy (Exposure and Response Prevention and some forms of CBT), education and family interventions. Because they are aware of how irrational their behavior is, many sufferers are ashamed of their actions and go to great lengths to hide their symptoms. It is extremely important that as a therapist, one is able to build a safe and accepting therapeutic environment and also structures therapy based on the unique presentation of illness where sometimes symptoms themselves may cause non compliance to therapy process. The author presents and discusses a case where Cognitive Behavior Therapy was used.

**Keywords:** *Obsessive Compulsive Disorder, Cognitive Behavior Therapy, Psychological Management*

Obsessive thoughts and compulsive urges are part of the normal feedback and control loop between our thoughts and our actions. It is only when these obsessive thoughts become so intense and frequent and these compulsive rituals become so extensive that they interfere with an individual's functioning that the diagnosis of Obsessive Compulsive Disorder (OCD) is made. It is an anxiety disorder that, until quite recently, was regarded as a rare condition. Recent studies have shown that OCD is much more common than previously thought and as many as 2 in every 100 individuals may be suffering from it.

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OCD is characterized by persistent, intrusive, unwanted thoughts that the sufferer experiences as beyond his control. Such thoughts are often very distressing and result in discomfort. The essential features of OCD are the repeated occurrence of obsessions and/or compulsions of sufficient severity that they are time-consuming or cause marked distress or impairment. Obsessions are unwanted, unacceptable intrusive and repetitive thoughts, images, or impulses that are associated with subjective resistance, are difficult to control, and generally produce distress even though the person having such thoughts may recognize their senselessness (Rachman, 1985). Their content often focuses on troubling, repulsive, or even nonsensical themes like about dirt and contamination, aggression, doubt, unacceptable sexual acts, blasphemous, and symmetry, precision and order.

Compulsions, on the other hand, are repetitive, stereotyped behaviors or mental acts that are usually performed in response to an obsession in order to prevent or reduce anxiety or distress. A compulsion is generally accompanied by an especially strong urge to carry out the ritual resulting in a diminished sense of voluntary control over the ritual (Rachman & Hodgson, 1980). Subjective resistance is often present, but the person eventually gives in to the overpowering urge to perform the ritual. Washing, checking, repeating specific behaviors or phrases, ordering (rearranging objects to restore balance or symmetry), hoarding, and mental rituals (i.e., repeating certain superstitious words, phrases, or prayers) are the most common compulsions. Many OCD sufferers also engage in rituals or compulsions that are persistent needs or urges to perform certain behaviors in order to reduce their anxiety or discomfort. Often the rituals are associated with an obsessional thought. For example, washing in order to avoid contamination follows thoughts about possible contamination. For some, there is no apparent connection between the intrusive thought and the behavior for example, not stepping on cracks in the sidewalk in order to avoid harm befalling one's family. Others still have no compulsive behaviors and suffer from obsessional thoughts alone, while others do not experience obsessions but have compulsive rituals alone.

### ***OCD and its management***

OCD is a chronic illness that usually may be treated in an outpatient setting. The mainstays of treatment of OCD includes Serotonergic antidepressant medications, particular forms of Behavior Therapy (Exposure and Response Prevention and some forms of CBT), education and family interventions, and, in extremely refractory cases, neurosurgery.

A set of patients who have achieved remission of symptoms with Behavior Therapy alone may never require medication and may instead require only returning to therapy if they face an increase in their symptoms. Also, another subset of patient is treated with a combined approach; these patients can discontinue medication, maintaining a remission with behavioral interventions alone. However, many patients require ongoing medication to prevent relapse.

Behavior therapy is a first-line treatment that should be undertaken with a psychotherapist who has specific training and experience in such treatment (most commonly a behaviorally

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trained psychologist). Some patients will not undertake this therapy; with perhaps 25% rejecting it and 25% dropping out of behavioral therapy, but it should definitely be encouraged if a competent behavioral therapist is available.

Exposure and response (or ritual) prevention (ERP) is the important and specific core element in behavior therapy for OCD. The patient rank orders OCD situations he or she perceives as threatening, and then the patient is systematically exposed to symptom triggers of gradually increasing intensity, while the individual is to suppress his or her usual ritualized response. This is generally challenging and often quite distressing for the patient, but when effectively done, it promotes unlearning of the strong link that has existed between having an urge and giving into the urge.

ERP is now usually administered as part of a broader program of CBT specifically designed for OCD. Other elements of CBT that are used include identifying and challenging the cognitive distortions of OCD symptoms (eg, intolerance of uncertainty, black-and-white thinking, focusing on unlikely extreme possibilities instead of viewing the future in a balanced manner, ascribing over importance to thoughts, excessive concern about the importance of one's thoughts, inflated sense of responsibility). After making the patient aware of his or her irrational thoughts, the therapist works to have the patient counter them with more rational thoughts and do cost/benefit analyses regarding performing his or her rituals.

Meditation and relaxation techniques may be useful, but not during active ERP. Psychodynamic psychotherapy alone has generally not been found to be helpful in ameliorating OCD symptoms.

### ***Considerations during therapy***

Most OCD sufferers can see the absurdity of their actions but still feel compelled to perform their various rituals. Because they are aware of how irrational their behavior is, many sufferers are ashamed of their actions and go to great lengths to hide their symptoms from family, friends, and, unfortunately, even their doctors. It is extremely important that as a therapist, one is able to build a safe and accepting therapeutic environment which aids the patient in sharing all their symptoms no matter how embarrassing or shameful they may be, as this is the only way that a suitable management plan can be designed for them.

It is important to keep in mind that many patients have more than one type of symptom so that individuals may engage in more than one type of ritual or have more than one type of obsessional thought. Also, that symptoms change over time and someone who is predominately a washer may, over time, develop checking rituals. In addition to changes in symptoms, the course of the disorder may also fluctuate over time in varying degrees for different patients, with periods of deterioration and periods of improvement. Sometimes the symptoms themselves will cause hindrance in the process of therapy. For example, some symptoms may be taking up a great deal of time, often resulting in them being late for

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appointments. Inter personal factors need to be taken into account too while designing a management plan for a patient. Apart from disrupting their own lives, it also frequently interferes with the lives of family members as the typical sufferer often asks the other members to do things a certain way or not to engage in certain behaviors or they are unable to perform their roles and responsibilities. It is important to take care of such factors and include the spouse or any other close family member as a co therapist.

The management thus, needs to be modified in light of all these factors and the response each patient shows to any kind of psychological treatment. In the context of above information, let us consider the case of R.C., who has been a patient of OCD for over 18 years and receiving pharmacological treatment for a good amount of that duration. In his previous inpatient stays, he was given psychological therapies of different modalities considering his current symptoms at that time. In subsequent times though, the therapy had to be modified to include emphasis on cognitive elements to manage the symptoms and his distress better.

### ***Participant:***

The case is Mr. R.C, 38 year old married male, studied up-to class X working as a Beetle (Pan) Shop owner, hailing from low socio economic status of rural Jharkhand. He was the third child out of total five siblings. RC had come to us with the complaints of repetitive thoughts of contamination and repetitive acts of washing, checking since the past 18 years and low mood since past 12 years. When detailed history and clinical interview was done, it was found out that there was nil contributory past history and family history of unspecified mental illness characterised by disorganized behaviour and aggressive behaviour in paternal aunt. Mental state examination revealed the patient was kempt, tidy, cooperative, with normal motor activity and speech. His affect was dysphoric, appropriate and communicable. In thought possession, obsessive thoughts about contamination from germs, repeated checking, counting compulsions, and hand washing and bathing were found. In thought content, ideas of low self confidence, worry about illness were there. Personal and social judgment was found to be impaired, and he had grade 4 insight.

His personal history when clarified in clinical interviews and initial sessions with the therapist revealed strict and punitive parenting by father, and shy and reserved traits since childhood. He grew up in an environment with perceived lack of emotional involvement from both parents, and financial strain. He now lived in an extended family where he was the nominal head, his wife was the functional head of the family. Decision making and problem solving in the family were democratic in nature. Primary, secondary and tertiary support systems were adequate and the family boundaries were semi-open. There was direct communication in the family. It was also found that there were critical comments in the family, and marital discord was present due to his illness, which further resulted in patient's reduced confidence in dealing with his illness.

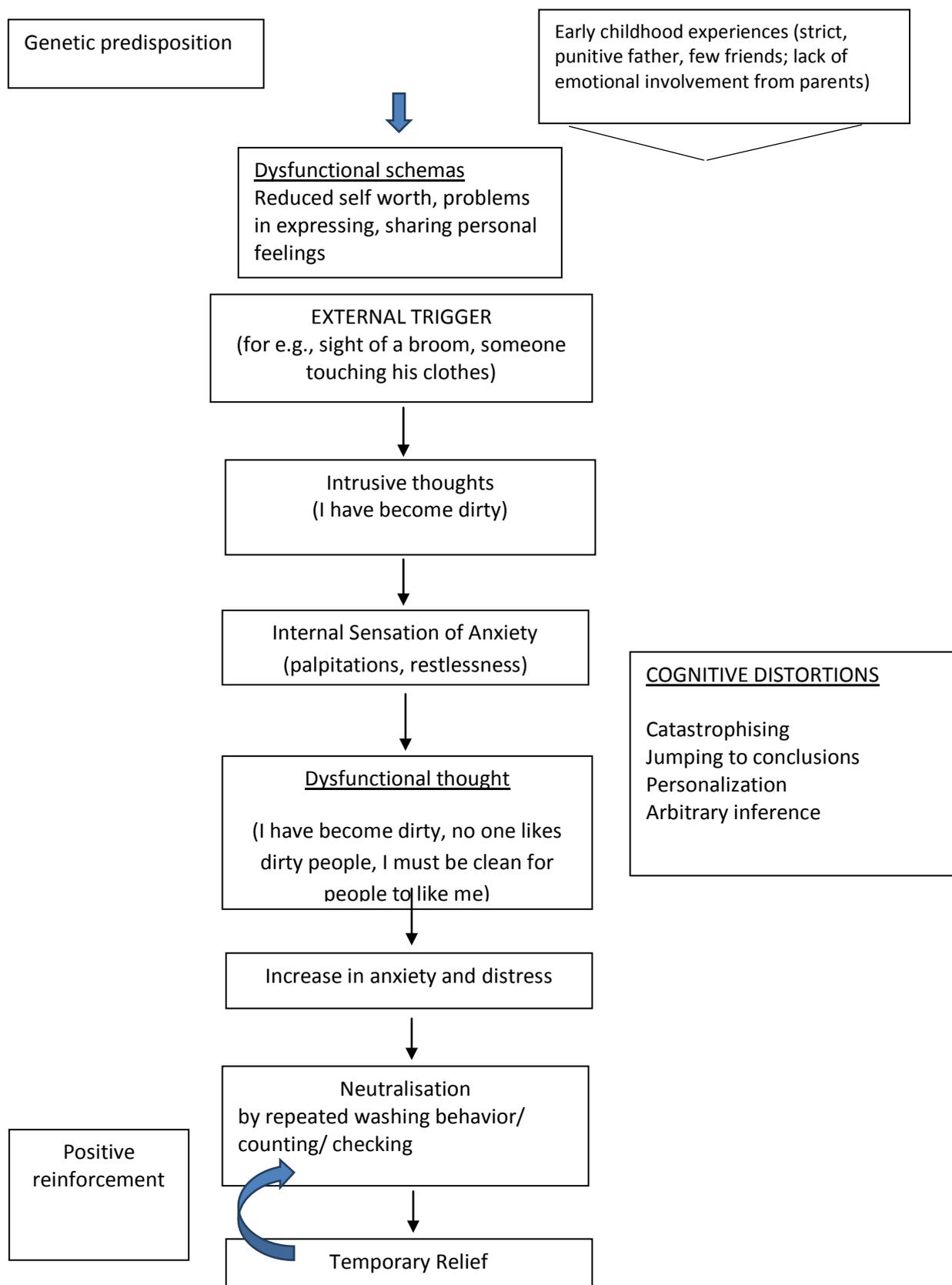
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Treatment History showed that patient had been on medications for Obsessive Compulsive Disorder since onset of his illness, however he would discontinue medications on his own after 8-10 months every time as he would feel completely well. He was also given 15 sessions of Exposure and Response Prevention therapy, twice in earlier admissions, where he reported good response and compliance. However, symptoms would resurface after some months again and he would have to seek treatment. In the previous admission, he was also taught breath watching, and progressive muscular relaxation but patient's therapy could not be continued for enough sessions to see any objective as well as subjective progress.

### ***Conceptualising the illness to guide the course of Therapy***

Considering all the information revealed during history taking and initial sessions with the therapist, the case conceptualization of the illness was done using a Cognitive Behavioral Approach, explained next.

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*The prognostic factors as assessed seemed to be the following:*

### **Good:**

- Motivation to engage in the therapeutic process
- Family support (for treatment)

### **Poor:**

- Long duration of illness
- Male gender
- Critical comments within family

### ***Rationale for selection of CBT:***

For the patient, his low self esteem and dysfunctional thoughts were found to be underlying his condition, making the need for a cognitive based therapy. Adding cognitive therapy to exposure and response prevention includes many of the same procedures, but they are presented as behavioural experiments to test out specific predictions. The emphasis is still on behavioural change and following valued directions in life. It attempts to improve engagement and provide a formulation that helps the patient to identify a broader range of cognitive processes (e.g. inflated responsibility and thought–action fusion) that maintain symptoms of OCD. The approach is to question these processes and the patient’s appraisals of their intrusive thoughts and urges. Cognitive–behavioural therapy has now been found to be superior to exposure and response prevention alone (P. M. Salkovskis, personal communication, 2007). Next, the further course of therapy while RC remained admitted, as given by the first author is elaborated.

**Frequency of sessions:** Sessions were taken thrice a week

**Total no of sessions taken:** 18

## **SHORT TERM AND LONG TERM GOALS**

### ***Short term:***

- Psychoeducation to the patient regarding Illness and Cognitive Behavioral perspective to his presentation of symptoms.

### ***Long term:***

- To reduce obsessive/intrusive thoughts
- To reduce compulsive acts

### ***Techniques used***

- Psychoeducation
- Socratic questioning
- Obsessional Thought Record
- Downward arrow technique
- Estimation of threat
- Disputing
- Behavioural experiments
- Deep breathing

## INITIAL PHASE

**Target:** Clarification of history, assessment, case formulation, and psycho-education

*No. of sessions: 3*

The clinical interview was done and history clarified with the patient. In the initial session, history was revised in detail and psychological formulation of the case was made. Baseline assessments were done and psychosocial factors were explored. Patient shared about his perceived lack of emotional involvement from his parents, even though basic materialistic needs were met. He also spoke of struggling in school, having to take care of financial responsibility early in life by starting work in class VII, then taking it up full time after passing Class X. Then, he discussed his current problems, after which he was psycho-educated regarding her illness in simple language. Patient had much knowledge from earlier therapeutic sessions also, so it was easy for him to relate to what was explained to him in the sessions. The patient was explained about the symptoms of obsessive compulsive disorder, mainly focusing on the unpleasant repetitive and distressing nature of obsessions, the patient trying to control compulsive rituals but not successfully for a long time. How the illness has affected his functioning at work, home and his marital life were discussed. The case formulation that was made was explained to him, and he seemed to agree with it. He was then explained the cognitive models of OCD, eliciting examples from him about threat perception, heightened sense of personal responsibility. He was even able to cite some examples of thought-action fusion and thought event fusion, even though he had difficulty verbalizing and articulating his experiences. He was able to identify phenomena as they were happening to him.

After this he was given the rationale of the therapy and how we will proceed with the therapy. He was briefly explained what the therapy will entail, his need for active and motivated participation, and activities like homeworks.

## MIDDLE PHASE

**Target-** Normalization of his experience, distressing and embarrassing thoughts, refuting dysfunctional patterns of thinking, reducing distress

*No. of session: 8*

Based on his experience and knowledge of previous interventions done with him, he was explained about anxiety using the sea wave metaphor that the anxiety will rise up like the sea wave and it will come down and return to the normal level after sometime just like the sea waves. He was found to already apply some of this knowledge to use in daily life, and not giving in the urge to wash hands repeatedly or for a long time. His most distress currently was because of his obsessional thoughts about contamination, in the bathroom and in the campus parks, where he would feel intense feelings of disgust and fear of contamination because he walked on wet grass, or feeling that splashes must have contaminated his clothes, etc.

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He was introduced to the ABC model, and explained about the cognitive link which is usually bypassed. Some examples were discussed, and socratic questioning was used to elicit this bypassed link, and bring to his awareness. He seemed to understand the concept better now. Then, Obsessional Thought Record was explained to him and he was asked to keep a track of such distressing thoughts throughout the day, along with a record of consequent quality and intensity of emotions. This would give both the therapist and patient a better understanding into his thinking processes, and a focus to work on. Later, he reported using the record helped him to focus his attention to his thoughts and to introspect on them.

When these examples were reviewed and explored further using downward arrow technique, it was found that apart from the actual fear of contamination, another major thought that was operating was that 'I am unlikable. I will be liked if I remain orderly, clean. If I don't remain clean, what will others say about me?'. Patient was then able to identify this as the bigger concern for him. He wanted to avoid anticipated insults, which made him check his face, eyes, and clothes again and again. This and his already present self doubts, reduced self confidence were operating under the disorder. This was reflected back to the patient.

Future sessions focussed on refuting such importance attached to insults, and overestimation of being insulted, as well as over estimation of threat perceived by germs. He was made aware of the discrepancy between his anticipated reality, and actual reality.

A behavior experiment was devised mutually, where patient and therapist would go to 5 people in the ward, including patients and ward staff, and ask about a feedback for the patient. Initially he resisted to the idea and felt anxious, with therapist's assurances he was able to muster up the courage to do the experiment as a check for his anticipated insults. It was not pre decided who these 5 people will be, and only at the time of actual experiment, patient and therapist agreed on approaching them and asking questions like how do they see the patient in the ward, what they think of him, how he presents himself. Later, when it was over patient summarized that people see him as disciplined, loving, clean, helping others and sharing their feelings and supporting them emotionally. Patient was surprised to get such feedback. He felt emotional after that, and needed time to reflect on the experience. He reported increased feelings of confidence, therapist appreciated him, and also made him aware of a general tendency to fall back on previous thinking patterns and discount the positives, so he was asked to remember the learning from this experiment. 0% people were out there to mock him, instead of his anticipated 100%.

Next focus was on teaching him adaptive thoughts to replace his maladaptive thoughts, for example 'few drops of water spilled on slippers will infect me' to 'few drops of water spilled on slippers will dry out soon, and it is a normal consequence of washing which itself is a sign of cleanliness'.

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To counter his frequent obsessive doubts about whether the nurses gave him wrong medicines, so he must check again and count again to make sure it was right or else it will mean something really bad, an estimation of probabilities for the same was done. One time his friend had received the wrong dose of medication, so he would expect mistakes 90% of the times (a subjective estimate), leading to a subjective anxiety of 70. (obtained from OTR) real probability of such an error was then calculated with the patient: Nurses give medications to nearly 80 patients, three times a day, for 30 days in a month, in which the patient had seen/heard of only one error made on the nurses' part, making it a probability of 1 in 7200 chances to commit an error. Awareness of this estimate, as compared to his anticipated error of 90 in 100 chances, made him relax a bit. Patient was able to realise he was again making errors of over estimation of threat, and discounting the many positive but focusing on one negative event (wrong dosage given to one patient). Estimation of odds was used for similar situations in order for him to deepen this insight thus achieved about his thought processes for example, using a pie chart to assess the possible reasons and their probability for which a doctor gets patient visits, making the real chance of dangerous and exotic diseases much less than what the patient anticipates and fears of.

On subsequent days, his anxiety ratings in thought record reduced. He reported being able to generalize to other situations as well (not limiting to specific OTR examples discussed with therapist).

### FINAL PHASE

#### Target- termination, feedback and future plan

##### *No. of sessions: 1*

During as well as after the completion of middle phase sessions he reported there was an improvement in his symptoms. He was able to resist his compulsive behavior of washing and he was now able to have better control over his obsession of contamination. His arranging, time spent in bathroom had reduced in the ward as reported by ward staff. The progress he made in therapy as well as the generalizations he made at home was reviewed and feedback was given. He was motivated to continue being aware of his errors of thinking, and keep challenging them. He was praised for his cooperation and active engagement in the therapeutic process. His personal responsibility in the gains he achieved was emphasized and appreciated. He was also motivated to take medicines regularly, as everytime this would become a reason of relapse, and come for regular follow up sessions. He was rated again on YBOCS, HAM A and HDRS.

### OUTCOME OF THE THERAPY

The outcome was measured both subjectively and objectively.

Scale	Pre-intervention score	Post-intervention score
YBOCS-Obsession scale	11	8
YBOCS-compulsion scale	11	6
YBOCS total score	22	14

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Scale	Pre-intervention score	Post-intervention score
HAM A	9	4
HDRS	12	5

### *Future plan for follow up sessions on OPD basis*

- Booster sessions
- Psycho-education of patient's family, with specific goal of reducing critical comments, and supporting the patient.

## CONCLUSION

As seen in the above case study, even though therapy of choice for OCD has been ERP, however based on the conceptualization of the causes underlying the illness as well as the maintaining and confounding factors which are determining the prognosis for a patient, one may need to modify one's therapeutic approach and work with the client not on the compulsive acts directly but the cognitions which are discovered to underlie these manifestations. Cognitive Behavior Therapy is effective for patients who are able to engage in at least a minimal degree of meta cognitive thinking guided by the therapist.

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