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Case Study

Managing obsessive compulsive disorder with cognitive behaviour therapy: a case study

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ABSTRACT

OCD is characterized by the presence of obsessions or compulsions that consumes time and significantly interferes with the individual's daily routine, work, family or social life, causing marked distress. OCD can affect people of all ages irrespective of their class, religion or gender and usually it starts in childhood. It is thought that 2-3% of the population has OCD. Cognitive behaviour therapy is evidence based psychotherapeutic treatment for obsessive compulsive disorder. The present case report attempts to highlight the effectiveness of CBT on OCD. CBT was applied along with the pharmacological treatment to the patient for 17 sessions. The combined treatment approach (CBT & pharmacological management) resulted in the patient presenting with no symptoms that interfered significantly with her life and most of the day was symptom-free and also gains obtained through therapy were sustained for longer time as patient remained asymptomatic. The patient remained under follow up for six months and found that combined treatment has better outcome than single interventional approach.

Keywords: *Obsessive Compulsive Disorder, Cognitive Behaviour Therapy*

Everyone feels anxiety, fear, uncertainty or worry at some time. These normal emotions and reactions help people protect themselves, stay safe, and solve problems. But for people with OCD, these feelings are taken to extremes. Its as if the brain's filter for sorting out what's dangerous from what's not dangerous isn't working properly. OCD is a type of anxiety disorder and people with OCD become preoccupied with whether something could be harmful, dangerous, wrong, or dirty or with thoughts about bad stuff that might happen. People with OCD feel strong urges to do certain things repeatedly called rituals or compulsions in order to banish the scary thoughts, to try to ward off the bad things they dread, or to make extra sure that things are safe or clean or right. By doing a ritual, someone with OCD is trying to feel absolutely certain that something bad won't happen.

OCD can affect people of all ages irrespective of their class, religion or gender and usually it starts in childhood. It is thought that 2-3% of the population has OCD (Black, 1996). Research suggests it may be due to an imbalance in a brain chemical called 'serotonin'. It

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may also run in families, suggesting genetic component (Kenesloi & Nemoda, 2010) and the lifetime prevalence of OCD was significantly higher in case compared with control relatives 11.7% vs. 2.7% (Nestadt et al., 2000). Very occasionally, OCD can start after an illness. It can also occur after a difficult time in their life like having an accident.

CASE SUMMARY

Client X, the 18 year old girl from lower socioeconomic status, presented to our clinic with complaints of frequently praying to god, along with sad mood, irritability, decreased hunger, increased tensions, since last two years, and increased since last one year. The girl had few sessions with another doctor, but she was referred with the request to see a female therapist. The client was very close and attached to her mother. She was worried that something might happen to her. She most of the time prayed to God "for" her mother. Her father was very fond of her. He died of a long illness during which she started praying to god frequently for his recovery. She was very attached to her father and often remembers and misses him. During her father's illness, her maternal uncle started living with them. He was also taking care of her father's business. In 2019 he left. Ever since then the client and her mother were living alone, and her paternal uncle who stays nearby often visits them.

History of Present Illness

Client's father fell ill in 2018 when her mother noticed that she had started praying to God excessively. She would continuously fold her hands in front of the idol. Owing to the illness her father died on (21st Feb. 2019), after which she became increasingly anxious and would pray to god very often. Folding her hands in front of the deity's picture (a big photography of Shivji in her room) would help her control her anxieties. In 2018, the anxieties and rituals though were persisting, were within control. These were considered only 'a little' more than normal by her mother. During this period, the above symptoms exaggerated only in wake of 'stressful' situations (such as nearing of examinations, being alone in the house or being scolded). In 2019 after her uncle cheated them in business (he had been taking care of her father's business ever since her father's death) and left home she felt, 'GOD IS ANNOYED WITH ME WHAT TO DO NOW', and would often appear disturbed and tensed.

After this episode her symptoms exaggerated and she started complaining of an unstoppable urge to fold her hands and pray to God. This started happening several times a day and irrespective of the place or situation. She was very distressed about not being able to 'control it' even in school. She narrated, 'When my mind wants to pray which ever place it may be i have to do my pray'. Slowly her conditions deteriorated so much that she did little else except praying to God. She also started doing things that if she forgot to pray to any deity God will' get angry' with her. And thus, during each ritual she 'had' to take names of all the deities. She said if she prays to Shankar ji, then she has to pray to gauri ji and also all other Gods. She complained of reduced concentration, especially in studies. This she said was mainly due to the recurrent thoughts. She also confirmed that these thoughts were her own and not put in or planted by someone else. Her mother complained that she was becoming easily irritable and would often loose her temper even in front of elders. She displayed some 'peculiarities' in her behaviour, such as wanting to go to a relative's house but one's there she would insist on getting back home immediately. This would happen much more often if her mother were not with her. To this the client said that she was often worried about her mother and was scared that something might happen to her. Her mother reported having observed that sometimes she would be seen talking to someone in an empty room or smiling to herself. In an explanation to this the client said that she usually remembered something.

The client complained of decreased sleep, appetite and energy levels. She complained of easy fatigability. Her mother was particularly worried about her measly diet. The client said that she didn't 'feel like' eating. Personal hygiene was found to be normal. This paper presents a case report of CBT with an adolescent girl diagnosed with the OCD disorder. The client was referred from another psychiatrist to our private clinic for psychotherapeutic intervention, aimed at treating her obsessive-compulsive disorder episodes.

Diagnosis- *Obsessive compulsive disorder*

Intervention

Cognitive behaviour therapy was administered in 17 sessions of one hour each duration for 20 weeks. Initially the family members were explained the nature of the problem, and explained that psychological therapy is an important adjunct to medication. The client was explained the basic concept of CBT. The intervention programme was developed with the following components,

1. *Jacobson Progressive Muscular Relaxation (JPMR) (Jacobson, 1938):* The psychological management of the client started with JPMR since there was marked anxiety. In the first two sessions she was taught in detail how to relax and then she was persuaded to practice it at home twice a day.
2. *Activity scheduling*: In next session an activity schedule was prepared in consultation with the patient to shift her focus of attention from obsessive thoughts to routine activities and responsibilities, and to maintain her daily routine as well as to engage her to give more importance to her routine activity instead of engaging in obsessive thoughts or compulsive acts. Initially client was not able to abide by the activity scheduled but after repeated encouragement, she started practicing it. Client was suggested to defocus her attention from obsessions and compulsions by keeping herself busy, in doing activities in the form of watching tv, listening to music, or focusing on the scheduled activity. In later sessions family therapy was made to understand in a rational and logical manner so as to how the faulty cognitions play significant role in the genesis and maintenance of her obsessions.
3. *Thought stopping:* - Simultaneously, thought stopping technique was applied. The client was told to imagine the content of her obsessive thoughts and simultaneously asked to say 'stop it', loudly in therapeutic session and later she was asked to practice it covertly. Her family members were educated about this and requested to monitor and report any noticeable change in her. The client reported significant improvement after five sessions. Though the thoughts were not completely absent but their frequency and associated anxiety was reported to be decreased.
4. *Cognitive restructuring:* - In the next step, the client was trained to monitor the automatic thoughts and to substitute more positive interpretations of her negative cognitions and alter her irrational beliefs that predispose her to distort her experiences. After 17 sessions, client reported much improvement in her symptoms. She was able to control her thoughts. Her family life improved. She remained in follow up for next four months and resumed normal functioning.

DISCUSSION

OCD is a type of anxiety disorder and people with OCD become preoccupied with whether something could be harmful, dangerous, wrong, or dirty or with thoughts about bad stuff that might happen. People with OCD feel strong urges to do certain things repeatedly called rituals or compulsions in order to banish the scary thoughts, to try to ward off the bad things they dread, or to make extra sure that things are safe or clean or right. By doing a ritual,

someone with OCD is trying to feel absolutely certain that something bad won't happen. The present case report was designed to assess the efficacy of CBT in improving OCD symptoms and daily functioning related to OCD disorder in an adolescence girl. After 17 sessions of CBT, child's OC episodes decreased significantly.

The client started going to college, and there was an increased initiative in doing household work. The findings of the present case study reflect that efficacy of CBT with regard to the reduction in OC symptoms is good and these findings are also supported by literature available in this area. In recent years, two treatment modalities have proven effective for OCD. SSRI'S and behaviour therapy. SSRI'S provides the symptomatic relief and behaviour therapy for long term management. Many studies have proven this (Dar & Greistet, 1992, Simpson et al, 1999, Alonso et al., 2001, Saxena et al., 2002, Halder et al., 2005, Tundo et al., 2007). The anxiety was reduced with help of JPMR. Behaviour techniques were useful in normalizing the day to day activities. Cognitive techniques were found to be helpful in modifying the negative thought to more positive alternative thoughts which led to improvement of coping strategies.

CONCLUSION

The case illustrated here indicates that psychotherapeutic interventions (Cognitive Behaviour therapy) are effective and highly indicated in obsessive compulsive disorders.

REFERENCES

Alonso, P., Menchon, JM., Pifarre, J., Matrix-Cols, D., Torres, L., Salgodo, P., & Vallejo, J. (2001). Long term follow up and predictors of clinical outcome in obsessive compulsive patients treated with serotonin reuptake inhibhitors and behaviour therapy. *Journal of Clinical Psychiatry*, 62, 7, 535- 540.

Black, D. W. (1996). Epidemiology and genetics of OCD: A review and discussion of future directions of research. CNS Spectrum, 1, 10-16.

Dar, R. & Greist, J. H. (1992). Behaviour therapy for obsessive compulsive disorder. *Psychiatric Clinics of North America*, 15, 885-894.

Halder, S., Singh, A. R. & Prakash, J. (2005). Efficacy of cognitive behaviour therapy for the treatment of OCD: a case report. *Indian Journal of Clinical Psychology*, 32, 133-136.

Jacobson, E. (1938). Progressive Relaxation. Chicago, IL, University of Chicago Press.

Kenesloi, E., & Nemoda, Z. (2010). Genetic factors in obsessive compulsive disorder: summary of genetic studies. *Psychiatria Hungarica: A Magyar Pszichiatriai Tarsasag Tudomanyas Folyoirata*, 25 (5), 378-393.

Nestadt, G., Samuels, J., Riddle, M., Joseph, O., Bienvenu, Liang, K, Y., & LaBuda, et al. (2000). A family study of obsessive-compulsive disorder. *Archives of General Psychiatry*, 57 (4), 358-363.

Saxena, S., Maidment, K. M., Vapnik, T., Gddeng, R. T., Rosen, R. M., Tarlow, G, & Bvstritsky, A. (2002). Obsessive compulsive hoarding: symptoms severity and response to multimodel treatment. *Journal of Clinical Psychiatry*, 63, 1, 21-27.

Simpson, H., B., Gorfinkle, K. S., & Leibowitz, M. R. (1999). Cognitive behaviour therapy as an adjunct to serotonin reuptake inhibhitors in obsessive compulsive disorder. An open trial. *Journal of Clinical Psychiatry*, 60, 9, 584-590.

Tundo, A., Salvati, L., Busto, G., Spigno, D., Falcini, R. (2007). Addiction of cognitive behaviour therapy for non respondees to medication for OCD: A Naturalistic Study. *Journal of Clinical Psychiatry, 6*8, 10, 1552-1556.

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Conflict of Interest
The author declared no conflict of interest.

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