ORIGINAL ARTICLE

CASE CONCEPTUALIZATION AND TREATMENT OF ATYPICAL SYMPTOMATOLOGY OF OCD USING COGNITIVE BEHAVIOR THERAPY

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Abstract

Obsessive Compulsive Disorder is characterized by obsessional thinking, compulsive behavior and varying degrees of anxiety and depression. The course of OCD can be episodic or chronic with latter being considered as treatment resistant and high levels of dependency on mental health services. This case study describes the process of CBT in the long-term outpatient care of a young man with OCD. The client came with the chief complaints of repeated thoughts of losing home registry and checking behaviors to reduce the anxiety associated with these thoughts, with total duration of 22 years. Problems in social functioning and performance in work were encountered by the patient but still leading a compromised quality of life. Objective assessment tools (Y-BOCS & BDI) were used to asses' severity of symptoms (anxiety and depression). A total number of 15 sessions were conducted once a week, each lasting 60-80 minutes. Results indicate considerable improvement in all outcome variables and maintenance of treatment gains. These findings provide evidence in support of potential usefulness of cognitive-behavioral interventions in the treatment of OCD.

Keywords: CBT, chronic, Obsessive Compulsive Disorder.

Introduction

Obsessive-compulsive disorder (OCD), one of the anxiety disorders, is a potentially disabling condition that can persist throughout a person's life. The individual who suffers from OCD becomes trapped in a pattern of repetitive thoughts and behaviors that are senseless and distressing but extremely difficult to overcome. OCD typically appears to be a chronic disorder with a waxing and waning course. Treatment modalities include pharmacological as well as psychological therapies. The treatment of OCD is usually more complicated than the treatment of other anxiety disorder. Unlike the situation with affective disorder, OCD patients tend to respond to medicines with only 30% to 60% symptoms reduction and patient tend remain chronically symptomatic [Jenike 1992].Cognitive models of OCD propose that problems are maintained by the client's sense of responsibility

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A number of case reports initially suggested that cognitive therapy is an effective treatment for OCD [Salkovskis,1983.,Headland and MacDonald,1987] especially when used adjunctively with behavioral techniques such as exposure and response prevention [Salkovskis and Warwick,1995]. Freeston et al. (1997) demonstrated that combined cognitive restructuring, exposure, and response prevention was substantially better than a wait-list control, and produced an 84% success rate that was maintained a year later. Viewing this approach, it is attempted to find out the efficacy of cognitive behavior intervention programme in the treatment of atypical case of 22 yrs of OCD. This case study highlights some of the main cognitive behavioral techniques (response prevention strategies- ERP, response delay and ritual restriction, and pie chart technique) that were employed and how these techniques were altered to suit patient's problems.

CASE HISTORY

A 45 yrs old, married, Hindu, male, clerk by profession, from middle socio-economic urban Background of Delhi presented with complaints of repeated thoughts of loosing home registry and checking behaviors for past 16 years. The total duration of illness was 22 yrs. His problem precipitated when he was forced by his colleagues to engage in corrupt practices.

Patient's problem started at age 23 when he got the job of clerk in sales tax dept. As this was his initial apprenticeship period, he would check his work repeatedly to ensure that everything done is right in order to prevent mistakes. This continued and after 5 years he got transferred from sales tax department to a school, where he was persuaded by his colleagues to indulge in corrupt practices, which he refused owing to his honest demeanor. After that, they prepared a fake document against him & threatened him continuously that they will sue him on the basis of that forged document. This created excessive fear & distress & he started checking all official documents in his hands & around, which could be used against him. Because of these events, he started remaining anxious, experiencing sadness of mood & loss of interest in daily activities. This continued for a period of months however no action was taken against himOn one occasion while sitting with a group of friends, one person remarked that if a person loses the house registry papers, they can be forged by another person & it is possible to take the possession over the former's house. After this incident client started fearing that his own house registry papers may get lost and stolen & his house may get taken over by someone. This fear let the patient to check his hands, pockets, clothes, pen, money etc. repeatedly to ensure that registry is not there. He would check these things up to 1-2 hours every time when he would go out of his house. He then kept the registry papers in the bank locker but his fear did not decrease. When he would not find satisfaction even after repeated checking, he would tell his wife to check his clothes by brushing them vigorously, who would comply with his instructions up to duration of even 2 hours. When the client would come back home, he would take off his clothes and roam around at home in his underclothes, to reassure himself that now the registry papers could not get stuck in his clothes and thereby stolen. While walking to his workplace, he would stand on any speed breaker and would see the surrounding area up to half an hour to check if the registry papers have fallen off from his pockets, despite knowing that he was not carrying them. He would tear any scrap of paper found on the road to reassure himself, even if that paper was his home registry document, he had now destroyed it. He would suspect his wife & sister-in-law for keeping registry in his clothes, as they were the only outsiders at home, he would make them swear repeatedly for reassurance and later on would feel guilty about it.

Gradually his checking of hands increased to 2-3 hours at one time in a day, resulting in severe impairment in his daily activities. He would also get a doubt of having made a mistake in calculations and would repeatedly check them 2-3 times. Currently the total time spent on checking compulsions is 4-5 hours a day. Detailed explanation of checking behaviors While leaving home for office patient starts having repetitive thoughts of losing home registry papers and doubts of having the same with him which makes the patient anxious followed by checking behaviors explained below. Checking of hands while leaving home for office, patient starts checking of his hands and keeps on checking until he reaches the office (for duration of 1& half hour). During this entire period he keeps his hands at a

distance from the body, he also checks between his fingers to ensure that registry papers are not sticking on his hands. He ends this checking by sitting on his office chair, checking for at least 10 minutes, even in the presence of his colleagues.

Checking papers: while leaving home for office he checks all the papers which he carries with him for 15-20 minutes. He reads each and every letter written on the paper repeatedly. When he does not find satisfaction, he takes reassurance from his daughter, despite knowing they are not registry papers.

Checking money: Checking each currency note that he carries with him, on both the sides for 6-7 mnts and feels satisfied only after seeing repeatedly Gandhi's image on them.

Spectacles and pen: Moving his hand on their surface very minutely observing and checking their smallest edges for 4-5 mnts each, despite knowing that registry is so big & cannot come inside them.

Handkerchief: touching its whole surface with palm & folding it to as many times as possible till it becomes so small in size that it disappears in the fist (5-7 mnts.)

Pockets: Checking pockets and shaking the trousers rigorously (5 mnts.)

Pre-morbid personality: Patient's pre-morbid personality is characterized by Guilt proneness and high tendency to assume personal responsibility for harm with limited social networks.

Medical and family history: Patient is on medication for the last 15 years. He belongs to a joint family. The patient's wife is in Delhi police and daughter is studying in 10th Std. He describes them as loving and cooperative, even for his repetitive reassurance seeking. Other family members, display irritation at the patient's reassurance seeking, however, are maintaining normal IPR. There is past history of irregular cannabis abuse with psychosis in father.

ASSESMENT AND INTERVENTION PROGRAMME

Assessment:

- Cognitive behavioural assessment designed to elicit the role of thoughts, feeling and behaviours in the development of a formulation of the problem.
- The Yale-Brown Obsessive-Compulsive Scale Y-BOCS [Goodman1989a., Goodman1989b].
- Beck Depression Inventory –BDI [Beck,1988].

Single case design with pre- and post-therapy assessment was adopted. Cognitive behavior therapy was administered in 15 sessions over 16 weeks. Initially the patient was explained basic concept of cognitive behavior therapy. The contents of the sessions in the therapy were kept flexible, taking into consideration the specific needs of the client. The intervention programme was developed with the following components:

EARLY PHASE OF TREATMENT

Therapist client joining: The development of a therapeutic relationship is critically important. Rapport was established by consistent use of the core conditions of genuineness, respect and accurate empathy. The worker was directive, active, friendly and used feedback, containment of feelings, reality testing and self-disclosure to develop the real relationship. Self-disclosure was also used to normalize situations and promote discussion of real life difficulties. Length of sessions was determined by the client's capacity at the moment and would range from 60 to 80 minutes or more.

Distinguishing between intrusions and appraisals Over the course of the first few sessions as the patient became familiar with the collaborative nature of work, it usually becomes easier for patients to identify their automatic thoughts. Patient was helped to understand that the problem he is facing is not of intrusive thoughts but of his interpretation of these thoughts. By using Socratic Questioning technique his intrusive thoughts were distinguished from his appraisals or negative automatic thoughts Four multipliers identified which were found as increasing the intensity and duration of compulsive checking: Extremely high responsibility X perceived probability of harm X predicted seriousness of the harm or overestimation of risk X guilt.

Explained the psychological formulation of the case: patient was explained the connections between the current problem pattern, early learning and critical incidents and the inter relations between the thought, feelings and behavior. Treatment plan was also discussed based on the psychological formulation.

MIDDLE PHASE

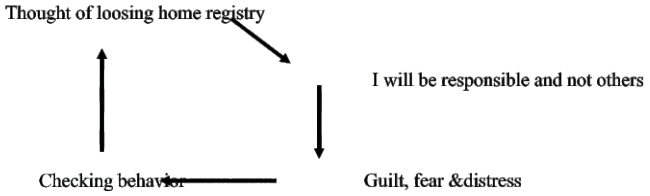
Psycho-educating the patient

psychological formulation.

MIDDLE PHASE

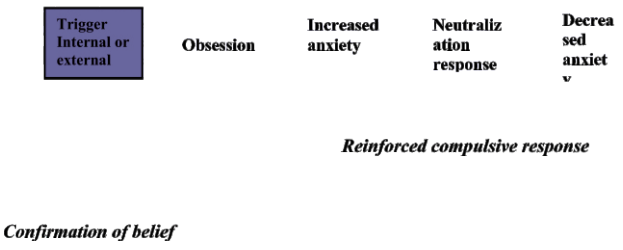
Psycho-educating the patient

- Normalizing the thoughts: Patient's doubts and misconceptions related to illness were removed by giving a very simple description of OCD including its definition, facts and figures on prevalence, etiology and nature of treatment (CBT). He was explained that intrusions are common occurrences that most people have. It is not a sign of mental illness and these thoughts are universal. It helped him to learn that he is suffering from an illness shared by others thus reducing his sense of shame and guilt about his symptoms.
- How a person's reactions to his intrusions contribute to these difficulties: As the patient had a tendency to overestimate the risk and responsibility he was explained that it is not the thought which actually causes distress and suffering rather the way we interpret these thoughts and the negative interpretation assigned to them is responsible for their increase in intensity and frequency and for the transformation into obsession. Shown in Figure -I



- Nature of neutralizing activities: By using a Vicious circle linking O & C, (shown in Fig.II) Patient was explained that because of the tension reducing aspect of the compulsion, this learned behavior becomes reinforced and eventually fixed. Compulsions in turn, actually reinforce anxiety because they prevent habituation from occurring, that is a decrease in fear associated with the stimulus (habituation) does not occur.

Fig. II



The relationship between depressed mood and OCD was also explained to him.

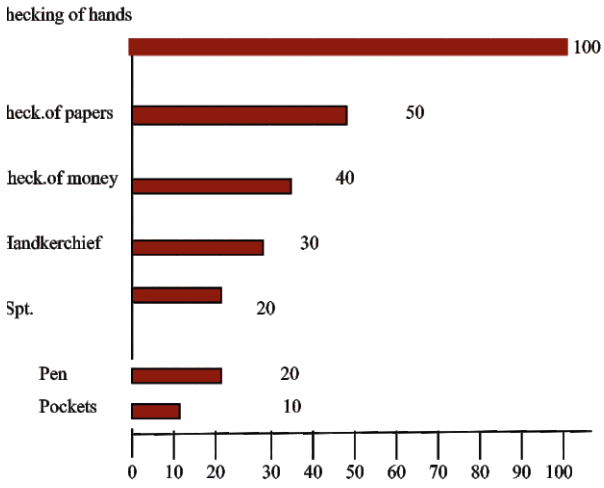
Involvement of family members: - In later sessions family therapy was used to maintain social support and monitor the schedule of the patient. The family members were made to understand in a rational and logical manner how the faulty cognitions play significant role in the genesis and maintenance of obsessions and compulsions. They were explained the role of reassurance in maintaining patient's symptoms and were taught to withhold reassurance.

ERP initiated:

After explaining the principle of ERP, an ordered list of checking items is placed on a hierarchy, constructed in collaboration with the patient. A simple rating scale of 0-100 (often called a SUDS for Subjective Units of Distressss Scale) was used to rate the expected amount of anxiety associated with each item, with the most distressing item at the top of the hierarchy. After an item from the hierarchy was faced in session with the therapist, the patient then practiced self-exposure of the same exposure as daily homework. For eg. He was asked to prevent himself from response of checking pen & pockets etc. Patient's difficulties in doing these homework assignments were handled by repeating the sessions.

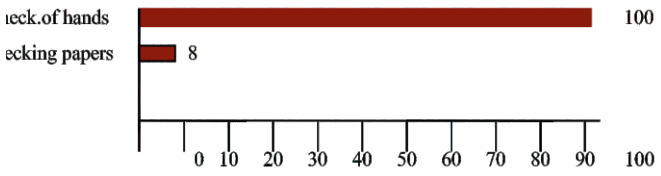
Once mastered, the patient then faced the next progressively more distressing object to produce higher levels of anxiety. The patient learned (1) that the feared consequence will not occur, (2) to better tolerate anxiety, and (3) that anxiety naturally diminishes over time. Represented in Fig.III

Fig. III



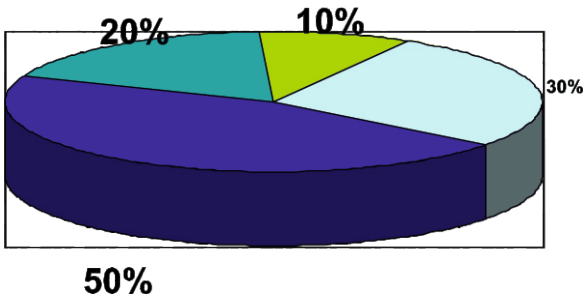
Improvement with ERP: After few sessions' improvement was assessed, significant reduction was found in his compulsive behaviors which were targeted except his checking of hands, which indicated no reduction in his high responsibility appraisal. Represented in Fig.IV

Fig.IV



Use of Pie chart technique (PCT): PCT was used to modify the overestimation of responsibility and helping the patient to reattribute responsibility. Patient was asked to list all those factors which can contribute to the loss of his home registry, including his own role. Patient gave rating in the following manner: (Represented in fig.V)

Fig.V



- Brother and father taking registry out for some work and loosing it. (30%)
- Thief stealing registry. (50%)
- Mother's carelessness while opening the almirah and stolen by servant (20%).
- Hiding registry by the sister-in-law (10%)

Therapist then asked the patient to rate his own contribution in losing his home registry. Patient rated it (0%).

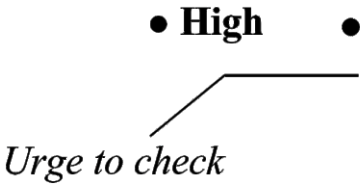
Patient then divided the pie into segments & assigned the values in the following manner:

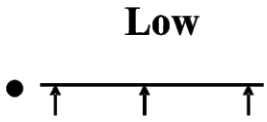
Based on this chart patient was then asked, what would be the likely cause if your home registry get lost. Patient said, "Stolen by thief".

He was then asked how strong he would rate his own responsibility for loosing home registry which he reported 0%. Patient was then made to reappraise his own role as being smaller than originally predicted.

Patient was also explained the connection between responsibility and control and the absence of responsibility where no control is available.

Despite the use of PIE chart technique for deliberate reduction in responsibility of the patient, it did not follow the reduction in discomfort and his urge to carry out the compulsive checking. (Represented in fig. VI)





Baseline responsibility **Induced Transfer of responsibility**

Use of response prevention strategy (RPS): Again for the problem of hand checking RPS was used but now in a graded manner. Two strategies used for this are:

Response delay and ritual restriction: Patient was taught to delay his response of hands checking. He was taught that every time when he feels like checking of his hands, he has to prevent himself for 5 minutes from hand checking. Along with this he was taught ritual restriction, after every 5 minutes he has to check his hands for only a limited time period i.e for only 1 minute. Restriction of hands checking was then gradually increased along with increase in response delay.

Feedback of response prevention strategy: After few sessions patient reported significant improvement i.e reduction in time spent from 1 & half hour to 15 minutes.

ENDING PHASE

Assessment of Pre-post scores of different measures of depression and OCD (Represented in Fig.VII)

Relapse Prevention: Relapse prevention involved asking the patient to identify what he had learned during therapy and how he overcame difficulties.

BDI	27 (Moderate)	17 (Mild)
Y-BOCS	22 (Moderate)	9 (Mild)

A preventive plan was developed, emphasizing the continued use of self exposure and response prevention, using a self-help manual for obsessive compulsive problems [Ash & Marks,1995]. By the time he was able to draw up his own goals for future exposure and practice these alone

DISCUSSION

Present study described the process of CBT in the long-term outpatient care of a young man with 22 yrs of OCD. The client came with the chief complaints of repeated thoughts of losing home registry and checking behaviors to reduce the anxiety associated with these thoughts. After 15 sessions, each lasting 60-80 minutes, considerable improvement was found in all outcome variables with maintenance of treatment gains. A number of case reports initially suggested that cognitive therapy is an effective treatment for OCD [Salkovskis,1983 - Headland K, MacDonald B,1987] especially when used adjunctively with behavioral techniques such as exposure and response prevention [Salkovskis & Warwick,1985]. This study thus provided evidence in support of potential usefulness of cognitive-behavioral interventions in the treatment of OCD. Bruch and Bond reported collaborative development of the case formulation as one of the most crucial parts of assessment and treatment, as a client must understand this if engagement in therapy is to be achieved [Ash & Marks,1995]. Formulation can also help to overcome some of the difficulties encountered in therapy. For example in this case study, patient found some of the early tasks very difficult and didn't make much progress. At times he would come with some excuses for not doing his homework. Further Salkovski and Kirk reported that relapse rates in OCD can be as high as 40 per cent [Hawton,1986]. So a relapse prevention plan was developed, emphasizing the continued use of self exposure and response prevention, using a self-help manual for obsessive compulsive problems [Ash & Marks,1995].

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