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Efficacy of Cognitive Behavior Therapy and Exposure Response Prevention for Obsessive Compulsive Disorders

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This article includes case study in an attempt to provide therapeutic intervention to woman brought to Government Hospital with presenting complaints of excessive hand washing, bathing, checking kitchen stove, cup boards and locks and anxiety. Informal and formal assessment was carried out which included Clinical Interview, Mental Status Examination, DSM-V checklist and Dysfunctional Thought Record and standardized tool (Y-BOCS), after which client was diagnosed with Obsessive Compulsive Disorder With fair Insight. The associate psychologist devised management plan which included Cognitive and Behavior Therapy (CBT) and Exposure and Response Prevention (ERP), it was completed in total 15 sessions. Patient was assessed again at post treatment level where she showed 80 % improvement as revealed by marked decrease in intensity of her symptoms. This study implies the efficacy of ERP and CBT for Management of OCD patients.

Keyword: Obsessive Compulsive Disorder, ERP, CBT

According to DSM-5 Obsessive Compulsive Disorder is diagnosed when obsessions or compulsions or both are present and these are time consuming and distressing for the individual. Obsessions can be defined as recurrent and persistent thoughts, urges, or images that are intrusive and not wanted, whereas compulsions are repetitive rituals manifested in the form of behavior or mental acts that an individual feels compulsory to perform in response to any obsession. There are many different sub types of OCD which involves different themes related to contamination, checking, ordering, sexual obsessions, and religious

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obsessions. Compulsions include neutralizing these obsessions by performing rituals in the form of checking, washing, counting, ordering etc. The worldwide prevalence of OCD in DSM-5 is reported to be around 1.1 %-1.8 %. Females are reported to be affected more than males in adulthood (American Psychiatric Association, 2013).

There are different causes for the development of OCD which are explained by different perspective including psychodynamic, behavior, and cognitive, socio-cultural perspective. The cognitive theory (Salkoviskis, Clark & Gelder, 1996) proposed that the OCD is characterized by cognitive distortion of "inflated responsibility" which combine with negative mood and motivate towards neutralizing actions which may include compulsive behaviors such as washing and checking.

The cognitive-behavioral model (Berman, Elliott, & Wilhelm, 2016) proposes that obsessions and compulsions arise from dysfunctional beliefs that one holds and strength of that belief. In people with OCD, these intrusive thoughts can become obsessions if they are appraised as personally. These appraisals will lead to high amounts of distress; which one then attempts to reduce with compulsions. These compulsions result in temporary anxiety reduction, but reinforces the maladaptive beliefs that led to the negative appraisal in the first place, thus the cycle of obsessions and compulsions continues as in this case the obsession of contamination resulted in high amount of distress which was removed by performing rituals of excessive hand washing that resulted in the temporary relief but it reinforced the negative appraisal in the first place thus perpetuating the cycle of obsessions and compulsions.

Objective

- To evaluate the effectiveness of Cognitive Behavior Therapy and Exposure and Response Prevention in the treatment of OCD.

Hypothesis

- Cognitive Behavior Therapy and Exposure and Response Prevention are likely to reduce the symptoms of OCD.

Method

Research Design

A×B×A single case research design was used to determine the efficacy of Cognitive Behavior Therapy and Exposure and Response Prevention in the treatment of OCD. The sample comprised of a single case (N=1).

Case Description/Sample Characteristics

The patient was 30 years old educated till intermediate, married woman, who belonged to lower class socio economic status, her father was a labor and her mother was a house wife, her relationship with her parents were satisfactory, there was indication of physical illness in her family, however there wasn't any psychological illness reported in them .She had 8 siblings and was 2nd last born among her siblings, all of them were married, the client had satisfactory relationship with all of them.

The client didn't have any history of any pre or post natal or any birth complications, she denied having any neurotic traits. She achieved puberty at the age of 12 years. She didn't have prior information about it thus it was very much disturbing for her but she eventually learned to manage it. No homosexual or heterosexual relationship was reported.

The client got her early education from Urdu medium school and completed her education up to F.A. she didn't persue her education further and started working as a teacher at a nearby school, there she worked for 12 years, then she got married at the age of 29 years, after marriage she left her profession and became house wife. It was an arranged marriage. She had been married for 1 year but didn't have any child however she mentioned that her physical relationship with her husband was satisfactory, however, there wasn't proper understanding between them as his husband was controlling, besides she also had conflictual relationship with her in-laws, who lived with her.

The patient was an introvert person. She didn't have many close friends and didn't like to talk much, however, she reported that she was capable of making her decisions on her own and didn't face any difficulty in this regard before the onset of problem.

She was referred to the clinical psychologist with the presenting complaints of excessive hand washing, bathing, checking kitchen stove, cup boards and locks, anxiety. She also had complaints of increased

need for sleep, decreased appetite and decreased self esteem; all these symptoms had caused significant distress in her life for around year.

History of Present Illness

The patient reported that her symptoms started 2 to 3 year earlier when for no apparent reason, she started spending more time in washroom for the purpose of cleaning, started checking cup board, locks and stoves, however these symptoms didn't cause any significant distress in her normal area of functioning. When the client got married, the intensity of the symptoms increased and it started to disrupt her daily life functioning. She started to spend almost 10 minutes to wash her hands when they were contaminated with dirt. She took almost 1 to 1 hour 30 minutes to take bath; her symptoms gradually intensified and with the fear of having excessive thoughts about contamination her diet and water intake gradually reduced as this would require going to washroom.

The patient sought psychological help one month earlier from Jinnah hospital but she reported no betterment in her condition so she started her treatment in Lahore General Hospital. The home environment was reported to be very much troublesome. There wasn't any proper understanding between her and her husband. And her mother in law was also very strict which lead to further more anxiety. Her husband had left her for 3 months and asked that she can come home after the complete treatment of her illness. She was determined to fight this disorder for which she had subsequent support of her parents and brothers.

Assessment Measures

The patient was assessed both formally and informally to gain detail insight about her problems and to confirm her diagnosis. The informal assessment was carried out with the help of Clinical Interview, Mental Status Examination; Subjective Ratings of the Symptoms, Dysfunctional Thought Record and by administering DSM-5 checklist for OCD translated in Urdu. The formal assessment was carried out with the help of standardized tool i.e. Yale Brown Obsessive Compulsive Scale (Y-BOCS). The summary of the results obtained from Subjective Rating of the Symptoms and Y-BOCS are given in table 1:

Table 1
Table for the severity of the symptoms

Symptoms	Severity of the symptoms
Excessive hand washing	10
Excessive bathing	10
Obsessive thoughts	10
Excessive checking of kitchen stoves. Cupboards and locks.	08
Increased sleep	05

Table 2
Yale Brown Obsessive Compulsive Scale scores

	Obsessions	Compulsions	Total	Inference
Score	10	13	23	Moderate level OCD

The patient obtained more score on the compulsion sub scale which meant that the performance of rituals were more disturbing for her as compared to obsessions , the total score of 23 indicated that she had moderate level of OCD. The patient was diagnosed with 300.3(F42) Obsessive Compulsive Disorder with fair insight.

Procedure

The procedure of treatment of the patient involved both medication and psychotherapy with the trainee clinical psychologist; both of these were planned simultaneously for the purpose of helping client manage her symptoms. The medication was prescribed by the psychiatrist and the trainee clinical psychologist devised a management plan for psychotherapy. A total of 15 sessions were conducted with the client the initial few sessions involved supportive work, detailed assessment, normalization and calming exercise. After proper establishment of rapport and thorough assessment the next sessions involved the introduction to the CBT and Exposure and Response Prevention (ERP). The SUDS (Subjective Unit of Distress Scale) were

obtained and then the patient was exposed to the contamination related obsessions in hierarchy of least to highest anxiety provoking situation, this involved exposure firstly at the imaginal level and then gradually to the highest anxiety provoking situation, during all this process she was taught the phenomenon of habituation and was asked to practice it during all the exposures, until her anxiety level reduced. Once the ERP was completed, the later sessions involved work on her cognitive restructuring which involved identifying her cognitive distortion through vertical dissent technique and then restructuring it by obtaining cost and benefit analysis, alternative thought record. The last few sessions involved managing her associated symptoms which involved anger management, assertiveness training and self esteem building exercise; they also involved guiding about the relapse prevention and providing therapy blue print and providing guidelines to the family. One follow up session was carried out to further check her condition. The session wise treatment is given below.

Table 3
Session wise management plan

Session No 1 Presenting Complaints Supportive Work Mental Status Examination DSM checklist Deep breathing Exercise	Session No 2 Feedback History Taking Formal Assessment (Y-BOCS). Diversion Technique
Session No 3 Feedback Activity Scheduling Psycho education about OCD Obtaining Subjective Unit for Distress Scale (SUDS)	Session No 4 Feedback of previous session Brief history Coping Statements
Session No 5 Introduction to the Cognitive Behavior Therapy (CBT) Identifying Cognitive Distortion(Vertical Descent)	Session No 6 Feedback History from informant Preparatory for Exposure and Response Prevention

Dysfunctional Thought Record Chart (DTR) Home work	Home work (DTR, Activity schedule)
Session No 7 Feedback Exposure and Response Prevention continued	Session No 8 Feedback Exposure and response prevention continued
Session No 9 Feedback Exposure and Response Prevention Cognitive Restructuring Guiding about checking compulsions Post assessment of subjective symptoms	Session No 10 Post assessment(Yale Brown Obsessive Compulsive Scale) Cognitive Restructuring continued
Session No 11 Feedback Cognitive restructuring continued Home work (Alternate thought record chart)	Session No 12 Feedback Cognitive restructuring continued
Session No 13 Feedback Relapse prevention Therapy blue print	Session No 14 Feedback Family Counseling
Session No 15 Follow up session	

Ethical Consideration

A verbal consent was taken from the patient to carry out intervention. The patient was educated regarding the procedure of therapy, approximate number and duration of sessions. The

confidentiality of the patient was ensured and the results were reported objectively.

Results

For the purpose of assessing effect of therapy on the patient, the post assessments were again carried out; this involved assessing again at informal level by means of subjective ratings of the symptoms as well as formal assessment of Y-BOCS again. The summary of these results are given below:

Table 4

Post Treatment Ratings for Severity of the Symptoms

Symptoms	Pre-treatment rating	Post –Treatment rating
Excessive hand washing	10	04
Excessive bathing	10	05
Obsessive thoughts	10	05
Excessive checking of kitchen stoves. Cupboards and locks.	08	03
Increased sleep	05	2

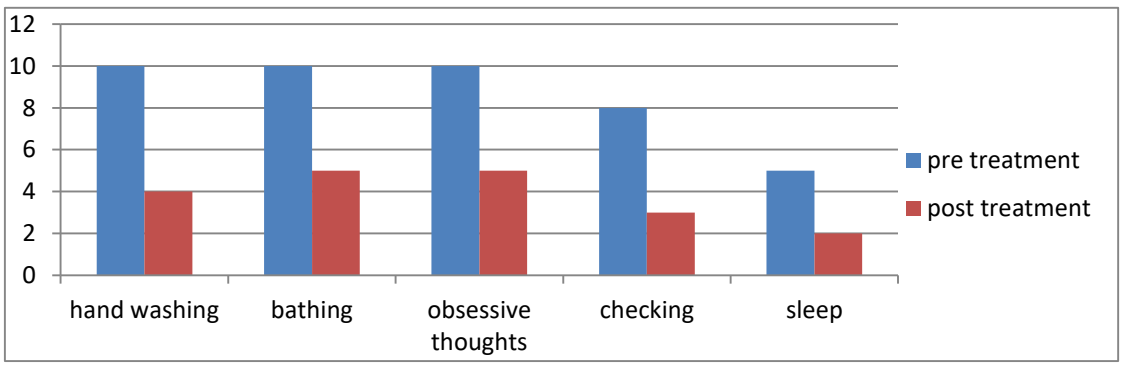

Figure 1. *Graphical Representation of pretreatment and post treatment ratings of Subjective Ratings*

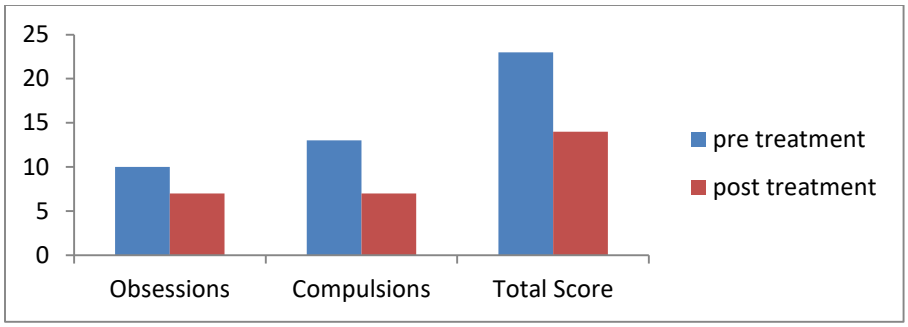

Figure 2. *Graphical Representation of pretreatment and post treatment ratings of Y-BOCS*

Discussion

There was 80 % improvement in the patient's condition after the application of different cognitive and behavioral technique which is evident from the post ratings as wells as formal assessment which indicated that she shifted towards low level of OCD after therapy. The total number of sessions carried out was 15. Reason for the betterment of her condition also included her compliance towards the therapy; she completed her homework assignments and worked very hard with motivation to counter her disorder, thus all these factors contributed to her improved condition.

Ponniah, Magiati, and Hollon (2013) reviewed different types of psychotherapies used for the treatment of OCD, and they concluded after reviewing forty- five studies that ERP and CBT were the most effective treatment method for OCD, the post treatment effect of our study shows the improvement in the condition of client, after administering CBT and ERP, thus our study is consistent with this study and proves effectiveness of these therapy.

McKay, Debbie, Fugen, Sabine, Stein, Kyrios, Matthews and Veale (2014) declared ERP to be first line evidence based treatment for OCD , which when administered simultaneously with cognitive therapy , targets specific symptom-related difficulties of OCD which increase tolerance from distress, adherence to treatment, and reduce drop out thus its treatment effect is durable thus the results of our case study is consistent with our finding as the CBT administration , involving ERP improved her adherence to the treatment and she responded to therapy well.

This study implies the effectiveness of CBT and ERP in the treatment of Obsessive Compulsive Disorder.

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