PSYCHOSOCIAL TREATMENT OF OBSESSIVE COMPULSIVE DISORDER – A CASE REPORT

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ABSTRACT

Obsessive compulsive disorder is a debilitating psychiatric illness affecting many people around the world. The current case report highlighted is of a client who was diagnosed with Obsessive Compulsive Disorder (OCD) and received treatment at a tertiary hospital centre. His socio occupational functioning was impaired and he had to quit his job due to the severity of his symptoms. Yale Brown Obsessive Compulsive scale (YBOCS) was administered at baseline which revealed a score 33 indicating severity of symptoms in the form of obsessions and compulsions. As part of his treatment along with pharmacological management, the therapist made a detailed assessment and a series of 20 controlled sessions of Exposure and Response Prevention (ERP) was provided which was a part of the psychosocial interventions. The YBOCS was administered during the course of his treatment to mark his progress and at the end of his treatment there was a remarkable decrease in the severity of the symptoms both at completion of therapy and during subsequent follow-up at one month of discharge, the client scored 10 on YBOCS indicating that the symptoms has reduced and were very too minimal to make a diagnosis, where a score of 16 is the cut off for making a diagnosis of OCD. The training he

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received gave him the courage to control his thoughts and behaviours which resulted in reduction of his compulsions and obsessions. Thereby his social occupational functioning improved and was able to lead a normal life.

Key words: Obsessive compulsive disorder (OCD), psycho social interventions, Exposure Response Prevention (ERP).

Introduction

Obsessive compulsive disorder (OCD) was considered for a long time to be a refractory psychiatry condition. This trend has been distorted in the last two decades where the grim prognosis for OCD has changed considerably with the introduction of behavioral treatment (Foa, 1996). Long considered a stubborn disorder, OCD has responded well to the combination of direct exposure and ritual prevention. The most widely studied behavioral approach used in the treatment of OCD includes exposure in vivo (i.e., in person) and ritual (response) prevention. Here the client is brought into contact with a feared object selected from a hierarchical list of anxiety-provoking obsessive situations. The client is asked not to engage in their usual ritualistic behavior. The combined behavioral intervention is based on the phenomenology specific to OCD in which obsessions increase discomfort, whereas compulsions reduce it. Thus, treatment should habituate obsessive fears and prevent rituals that interfere with anxiety reduction (Lam and Gail, 2008). This approach was initially practiced in the early 1960's have shown to be beneficial for clients who had washing rituals (Meyer, 1966). Written informed consent was obtained and with this background we discuss a case report using Exposure Response Prevention therapy for a client with obsessive compulsive disorder.

Case Report

Mr. M, 25 year old, unmarried male, completed his Bachelors in Engineering (B.E) specialized in computer science and has been unemployed for one year due to his current mental health. He sought professional help from the hospital for his repetitive uncontrollable thoughts relating to auspicious and inauspicious time as he was only able to perform work or activities only during this specific time while the rest of the time he was unable to do any work. Prelude to his problems he encountered two significant negative life events; the death of his elder sister who

committed suicide for reasons unknown to the family and as a result the father started consuming alcohol and died as a result of multiple organ failure.

Following the death of his father, his relatives started accusing him and his family that these negative events occurred as a result of the father and family being an atheist and not indulging in any religious rituals. It was this time that he started feeling guilty about not following any religious rituals and gradually started believing in superstitions and began performing rituals associated with it. He used to be preoccupied with things being right and wrong as well as about auspicious and inauspicious time. He would only be able to perform activities at auspicious times and would avoid activities at inauspicious times as he would start to have severe anxiety and get these repeated thoughts. As part of his daily activities he started following particular rituals like looking for even numbers when eating, avoiding places facing exits and avoids stepping on cracks between tiles etc. A detailed list of acts has been accounted in Table 1. Only on performing such acts he was able to complete the task at hand if not it would be incomplete, but in doing so he would take longer to complete tasks and would not complete it on time.

Both obsessions and compulsions can be time consuming with individuals spending countless hours engaging in compulsive behaviors. As a result, many experience negative impacts on life due to interpersonal, social, and work dysfunction (Franklin, 2000). It is common for individuals to experience difficulties in maintaining a career due to the symptoms (Clark, 2004) and it has been shown that individuals with OCD are four times more likely to be unemployed as compared to individuals in the general population without OCD (Franklin, 2000). Patient started to avoid work during office hours out of his belief that nothing is to be done during the inauspicious time due to which he found it difficult to meet his job deadlines and had to quit his job in two companies. He also started involving his family members and friends in performing his compulsive behaviors due to which the relationship with them deteriorated. As a result of these behaviours his social and occupational functioning was impaired. The client was diagnosed with Obsessive Compulsive Disorder - Mixed Obsessions Thoughts and Acts (WHO ICD-10) and was prescribed medications. In adjunct to his pharmacological treatment he was referred for Exposure Response Prevention Therapy.

Before initiating any intervention a baseline assessment was made to track the progress of the client during therapy. The Yale Brown Obsessive Compulsive Scale (YBOCS) was used to assess the severity of the OCD. The scale is a clinician-rated, 10-item scale, each item rated from 0 (no symptoms) to 4 (extreme symptoms) (total range, 0 to 40), with separate subtotals for severity of obsessions and compulsions. Scale is divided into two parts of five questions each, the Obsessions subscale and the Compulsions subscale. On each subscale five aspects of pathology are rated on scales ranging from 0 (no symptoms) to 4 (extreme symptoms):(1) time spent, (2) degree of interference, (3) distress, (4) resistance, and (5) perceived control over the symptom. YBOCS assigns lower scores to greater resistance as an indicator of health. Scores obtained from the subscales are summed to yield an YBOCS total (Woody et al., 1995). The results can be interpreted based on the total score: 0–7 is sub-clinical; 8–15 is mild; 16–23 is moderate; 24–31 is severe; 32–40 is extreme (Goodman et al., 1989). The client had scored 33 on Y-BOCS (extreme) at baseline and with this psychosocial intervention was initiated.

Intake and psychoeducation

Psycho education is defined as "Education or training of a person with a psychiatric disorder in subject areas that serve the goals of treatment and rehabilitation" (Goldman, 1988). Therapist initially explained the goal of therapy, process of therapy, the process of habituation and extinction and the frequency of sessions. He was also explained the need for practicing repeated exposure to anxiety provoking situations .The need of responsibility from patient's side for a better therapy outcome and need for keeping realistic expectations about outcome was also explained to the client. Later sessions focused on providing psycho-education to patient and mother regarding Obsessive Compulsive Disorder. The cause, course, symptoms and prognosis of the illness and the vicious cycle of OCD were also explained. A contract was taken with the patient and explained that the therapy is a kind of training for him on how to deal with his obsessions and compulsions and he will have to practice the therapy techniques after discharge in the feared situations in a consistent manner.

Bibliotherapy

Baker's (1987) defines Bibliotherapy as the use of literature and poetry in the treatment of people with emotional or mental illness. As cognitive therapists perceive learning processes as

the major mechanisms of change, nonfiction written material for educating individuals has been elected as the form to treat people (Sheehtman, 2009). Patient was asked to read the OCD Booklet - published by National Institute of Mental Health and Neurosciences (Reddy et al., 2008) to improve his understanding about his illness and his doubts were also clarified.

Thought Diary

Patient was helped to develop an awareness of his thoughts as obsessions and the associated rituals as compulsions. He was asked to document his obsessions on a daily basis in a diary, called a thought diary. He was asked to write down his obsessions and the interpretations associated with the obsessions. What he was doing when the obsession began, the content of the obsession, the meaning attributed to the obsession, and what he did in response to the obsession? The therapist reviewed the thought record with the patient and how the obsession was interpreted. The feelings of anxiety and fear were also monitored using thought diary.

Socratic questioning

Socratic questioning has been described as the gentle style of questioning, guiding the patient to elucidate their emotions and thoughts, to evaluate them, and to arrive at alternative interpretations and solutions. Questions are used for discovering new perspectives, for finding commonalities between situations, patterns of thinking and emotional synthesis, and for achieving change (Overholser, 1993,"a"; Overholser, 1993,"b"). Thoughts behind client's obsessions and compulsions were challenged using Socratic questioning. Therapist also tried to modify the way the client interpreted the occurrence or content of his thoughts in a less threatening way. He was made to understand that the problem lied not with the thoughts but with the meaning and significance that he attaches to those thoughts and the various strategies he adopts to suppress them. Probability estimations of threat, evidence for and against threat and for positive and negative ways of thinking; encouragement of alternative positive thoughts and re-attributions was also tried. In the last decade there has been considerable elaboration and refinement in the application of cognitive interventions to OCD. Salkovskis, for example, has described the use of cognitive procedures to modify pre-existing dysfunctional beliefs that lead to faulty interpretations or appraisals of obsessive intrusive thoughts (Salkovskis, 1996; Salkovskis, 1998).

Graded Exposure

The client was asked to make a list of anxiety provoking situations and rate those situations in the level of Subjective Units of Distress (SUD), that is, how anxious he would be if he is prevented from doing the compulsions associated with each obsession. This scale ranges from 0 to 100 and is a self-rating system designed to measure the degree of anxiety or distress a person feels (Pedrick, 2005). The list was ordered and is detailed below.

Table 1: Showing the different anxiety provoking situations and associated level of distress

Sl.No	Anxiety Triggering Situations	SUD %
1	Stepping on cracks between tiles	10
2	Writing the number 13	50
3	Looking for even numbers when eating	55
4	Doing activities between 7.30-7.48 am and 11.30-11.48 am	90
5	Doing an activity at 1:13, 2:13, 3:13…….	90
6	Doing an activity between 1-2pm	95
7	Doing any activity during a particular time of each day	100

Client was gradually exposed to these situations one by one starting with the situation with least SUD. Patient was encouraged to prevent himself from performing compulsions associated with the specific situations or to delay their compulsive response for as long as possible. The client was asked to wait for the ensuing anxiety to subside and not to avoid any of the situations as well as not to engage in any proxy and mental compulsions. He was re-exposed to the stimuli repeatedly till he became habituated to handle the obsessions and compulsions. By continuous repetition to the stimuli they gradually disappear or become less fearful. Experience during or after exposure and response prevention was discussed, and how this experience confirms or disconfirms the patient's expectation.

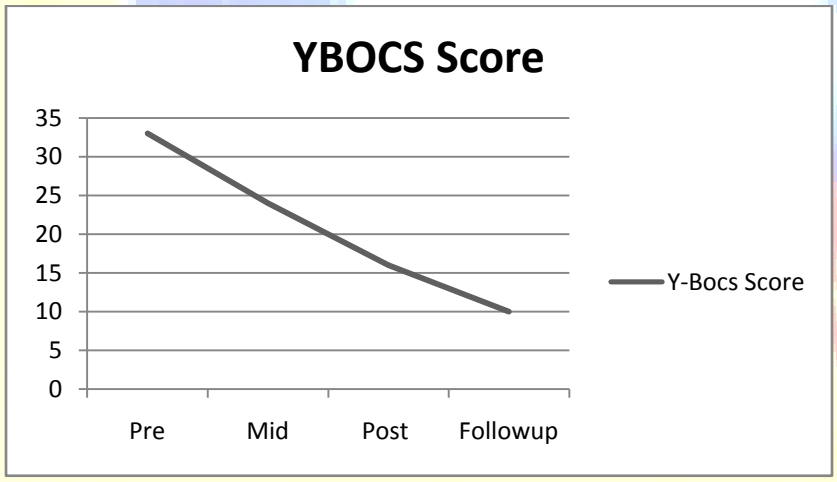
Y-BOCS ASSESSMENT

After completing the intervention the Yale Brown Obsessive Compulsive scale was re-administered to monitor patient's improvement. As seen initially the base line assessment before starting ERP was 33. Tracking the progress of the client from admission to discharge during the therapy and following the completion of therapy and discharge revealed a drastic decline in the severity scores to a completely sub clinical score.

Table 2: Showing the reduction of symptoms at different time points

YBOCS	PRE	MID	POST	FOLLOW UP
TIME	During Admission	After 15 days of Admission	After 30 days of Admission	After 30 days of Discharge
SCORE	33	24	16	10

Figure 1: Symptom reduction on YBOCS Score



Conclusion

A number of outcome studies have demonstrated the immediate and long term effectiveness of ERP for OCD. Scientific literature indicates that approximately 80% of patients significantly improve or achieve reduction in symptom severity following ERP therapy (Foa et al., 1998; Stanley and Turner, 1995). Clients receiving cognitive behavioral treatment exhibited significantly fewer symptoms post-treatment than those receiving treatment as usual. The

findings of this review suggest that psychological treatments derived from cognitive behavioral models are an effective treatment for adult patients with obsessive compulsive disorder (Gava et al., 2007). Similar findings were observed in the current case were following ERP therapy the clients symptoms had considerably decreased. Following one month of follow-up the symptom severity revealed a sub clinical level indicating that the psychosocial treatment would have benefited the client. In doing so the sessions helped the client to understand his dysfunctional beliefs and he was able to apply by himself the principles of ERP in the feared situations, thereby overcome his compulsions gradually. He joined for a job after 6 months of discharge as an engineer with a software company and is in remission. Since ERP is an evidence-based treatment for OCD, it is apparent that more social workers with professional training can incorporate ERP in practice.

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