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Original Research Paper

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TREATING OBSESSIVE COMPULSIVE DISORDER WITH ACCEPTANCE AND COMMITMENT THERAPY AND EXPOSURE AND RESPONSE PREVENTION– A CLINICAL CASE ILLUSTRATION

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ABSTRACT *Obsessive Compulsive Disorder (OCD) is ranked the top 10 of the most handicapping illnesses by lost income and decreased quality of life. Hence the need to overcome OCD is imminent. With the present case of OCD, Acceptance and Commitment Therapy (ACT) and Exposure Prevention Response (ERP) were used for treating OCD. Assessment was done using Yale Brown Obsessive Compulsive Scale and Weiss Functional Impairment Rating Scale – Self report. Results show that OCD reduced significantly after the treatment.*

KEYWORDS : Acceptance and commitment therapy, Exposure therapy, obsessive compulsive disorder

1. INTRODUCTION:

Obsessive–Compulsive Disorder (OCD) is a severe and debilitating mental disorder characterized by recurrent and intrusive thoughts, impulses, or doubts that cause marked anxiety or psychological distress in the individual, as well as behavioral or mental rituals that are performed in order to reduce distress caused by the obsessions. According to WHO, OCD is ranked the top 10 of the most handicapping illnesses by lost income and decreased quality of life (1). Despite the fact that most people suffering from OCD are aware of the irrational aspect of their thoughts, they are unable to stop the unwanted thoughts from reoccurring. Compulsions or rituals therefore develop in an effort to control thoughts and bring temporary relief from their anxiety. OCD may have a major negative impact on social relationship which can lead to marital discord or dissatisfaction, separation or divorce.

In terms of obsessions, fears may be related to contamination, doubts, orderliness, religion, morality, aggression, or sexuality. When it comes to compulsions, the most common are cleaning/ washing, checking, ordering/symmetry, and accumulating. More precisely, people with a fear of contamination are absorbed by worries such as fear of microbes, bacteria, diseases, bodily fluids, and chemicals. To ease their fears, they feel the urge to wash excessively (hands, body, teeth, clothes), clean household items or personal property, and avoid situations in which there are risks of contamination. Thus, OCD affects the mental health of a person and also the quality of life.

ACT is a third wave of cognitive behavior therapy that emphasizes accepting, understanding, challenging maladaptive behavior patterns and enhancement of mindfulness skills. It specifically focuses on decreasing avoidance and increasing psychological flexibility. Researchers, Professionals argue that ACT is more effective but lacks good quality research currently. ACT consists of six components to improve the way persons deal with their thoughts and feelings: Acceptance, Cognitive Defusion, Self-context, being present, Values and Committed Actions. This therapy facilitates the experiential exercises which connect the present moments fully as a conscious person and persisting and changing behavior in the chosen values and committed towards the particular goals.

Exposure and Response Prevention (ERP) is a therapy which encourages a client to face the fears and not to do any compulsive actions once the anxiety or obsessive thoughts have been triggered. ACT helps the patient to accept the repetitive thoughts and negative emotions associated with obsession thought and increases the psychological flexibility by committing to act in the service of value-added life even when the obsessions is absent.

Case Illustration:

Mrs. KA, 43 years old female, developed the symptoms of OCD five years ago. Initially, she had no difficulty in managing her symptoms. However, in due course, her mother-in-law and neighbors talked about intimate relationship and she started to believe that relationship is impure. She used to avoid her husband during later years. Whenever she went to the bathroom, she used to spend at least 45 minutes regularly for cleaning herself. At home, she would not open or close doors without covering her hand to protect herself. Her compulsive behavior increased and required larger amount of time. This disturbed social activity and spent limited time with her family. When she was surrounded by her relatives, she was able to control her compulsions.

2. Assessment And Diagnosis:

2.1 Assessment tools of OCD:

Psychological Assessment tools used on the basis of DSM IV TR for diagnosing OCD include self-report measures.

Yale Brown Obsessive Compulsive Scale:

The Yale Brown Obsessive Compulsive Scale was designed to remedy the problems of existing rating scales by providing a specific measure of the severity of symptoms of the obsessive-compulsive disorder. 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 totals of obsessions and compulsions.

Weiss Functional Impairment Rating Scale – Self report:

The Weiss Functional Impairment Rating Scale – Self report (WFIRS-S) is a self-report scale which includes 69 items divided into seven domains and developed to evaluate how an individual is actually able to function in inter-related domains; family, work/school, social skills and self-concept. Each item contains a four-point Likert rating scale from zero (never or not at all) to three (very often, very much). In addition, each item can be rated as 'not applicable' by the client if it is considered irrelevant to him/her. A higher score on each domain and on the total mean score indicates greater functional impairment.

3. Comprehensive Assessment And Formulation

3.1 Client Presentation:

KA, 43 years old female was well-groomed and was co-operative with the interview process. She maintained good eye contact, smiled appropriately and was open and forthright in her answers. She appeared comfortable and rapport was established quickly. Her speech rate and volume were normal and she answered questions articulately. Her range of affect was appropriate being euthymic on initial presentation. However, when she described the symptoms, her

affect changed and was punctuated with anxiety and tearfulness and she described tension and pain in hands and shoulders. KA described her mood as generally anxious and she described bouts of irritability. There was no evidence of any perceptual disturbance, formal thought disorder, suicidal ideation or intent. KA was optimistic and forward thinking, alert and oriented to time, place and person. Recent and remote memory appeared unimpaired and she answered questions about her past without difficulty. Insight was good and she exhibited good motivation to engage in treatment.

3.2 Personal History:

At the time of assessment, KA was a 43-year-oldfemale studied up to 10th std, housewife, living with her husband and two daughters. Her husband was 45 years old working as an accounts officer in a company. Currently, her first daughter is studying 11th std and second daughter is studying 6th std.

3.3 History of Presenting Problems and Precipitating Factors:

KA was referred by her GP as her compulsive behavior increased owing to concerns about emotional lability, tearfulness that disturbed her social activity.

KA presented for initial assessment and reported heightened general anxiety, manifest as agitation, difficulty relaxing, increased worry and anxiety whenever her husband came home, especially when she saw her husband masturbating and touching other things. She reported panic symptoms (increased heart rate, sweating, difficulty breathing, tension).

Other symptoms included decreased ability to concentrate; preoccupation with unpleasant thoughts that something bad will happen to her family members, guilt feeling.

3.4 Predisposing, Risk and Perpetuating Factors

KA reported of no episodes of depression or other psychiatric history within the family.

Strength and Protective Factors:

KA sought treatment promptly and demonstrated strong motivation and commitment to it. She was open and intelligent, displaying good insight into her symptoms of OCD by continuing to drive despite his fear. She had experienced a positive response from, medical personnel and felt hopeful about returning to her functioning with good family relationships and positive support from family and friends. KA had not suffered any serious physical injuries or debilitating or severe chronic pain. No other medications and substance use was reported.

3.5 Assessment results

The self-report questionnaires WFIRS - S, Y – OBCS were completed. The severity of the OCD was estimated with the Y-OBCS with the WFIRS – S scale. The relative scale score was expressed in Y – OBCS score obtained. The Y – OBCS score was 31 indicating severe OCD.

4. Description Of Treatment And Case Outcome

4.1 Applying the evidence

The research evidence to clinical case work (RK) emphasizes the importance of individual treatment program to consider the client's goals, values and preferences along with their personal circumstances and the experience of the practitioner.

4.2 Description of Treatment

The choice of psychological intervention including ACT, EX, (both imaginary and in vivo), in the current case of KA was based on all of the mentioned research. M Fuenmayor-C et al found that improvements were shown and reduction in the symptoms of OCD and increase in both physiological and psychological well-being. The specific components of the treatment program included psychoeducation about OCD and the rationale for EX treatment, ACT, relaxation training including breathing exercises and cognitive restructuring for maladaptive and dysfunctional beliefs resultant from the incident; imaginary prolonged exposure through verbal and written narrative with EFT treatment for sections of the narrative that produced strong emotional responses or distress; in vivo exposure for avoided driving stimuli and homework tasks. Before exposure treatment was initiated, KA's medical practitioner was consulted to exclude health-based contraindications.

4.3 Treatment Goals

- Decrease emotional distress and intrusive memories, thoughts and ruminations
- Decrease hyperarousal symptoms in general and on exposure to traumatic reminders
- Improve sleep and relaxation skills
- Improve overall functioning, sense of wellbeing indicated by reported improvements in concentration and sleep, decrease in muscle tension and change in trauma-influenced cognitions.

4.4 Length of Treatment

Treatment occurred across eight to ten sessions with the first five occurring weekly once and the last session monthly once or twice. The length of each Session was approximately 60 min with details of sessions included below. Each session included a session rating scale and SUDS rating for distress during the preceding week. All sessions followed the same pattern: events since the last session and homework was reviewed, the material from the previous session was reviewed, new home work was assigned, and behavioral commitment exercise were agreed upon. It is commitment to engage in valued - guide behavior instead of behavior guided by attempts to control one's private events.

1. Treatment Session 1 (Assessment and Psychoeducation)

After the assessment was complete and outcomes discussed, this session focused on: Initial rapport and Development of the clinical formulation; psychoeducation focused on reactions in OCD using specific examples; treatment rationales for prolonged imaginal and in vivo exposure to treat cognitive and behavioral avoidance, relaxation techniques, cognitive therapy for cognitive distortions and thoughts and a summary of the goals and format of treatment sessions.

Homework included: A handout to read on common reactions to trauma and share with family members and practice and breathing exercises twice a day to be recorded.

2. Treatment Session 2 (Psychoeducation and Relaxation Training)

This session focused on both psychoeducation about distinguishing between obsessions and compulsions, about how to work around the vicious cycle of OCD. It was also focus specific strategies such as relaxation techniques, breathing exercises for controlling anxiety rather than distracting herself in the present moment was explained.

3. Treatment Session 3 (Exposure Prevention Therapy)

Slowly graded exposure and relapse prevention in this session was started. Homework tasks were reviewed and a SUDS rating of 60 (100 being the highest) was reported by KA for the level of distress during the week. The focus of the session was prepared to analyze her danger thoughts and was on recognizing the effect of traumatic experiences on beliefs and thoughts.

The client was asked to identify and make a comprehensive list of objects of fear, danger thoughts. An automatic-thought monitoring form (situations, emotions, automatic thoughts) was utilized to demonstrate the concepts using examples of

unhelpful thinking patterns.

4. Treatment Session 4 to 6

The client was asked to identify and make a comprehensive list of fear of objects, body mind reactions, and danger thoughts. The client struggled in between sessions where she experienced some physiological symptoms such as shivering, headache, difficulty in breathing during graded exposure. She practiced three times per day. After several graded exposures throughout all the sessions, she reported significant reduction in washing her hands, cleaning her home, touching and cleaning her husband's clothes and bedroom.

5. Application of ACT and Exposure Therapy

During sessions 7 to 9, the patient's values and commitments including areas such as intimate relationship, social relationship, Parenting, Spirituality, Recreation, personal growth and physical well-being were discussed. We worked together during the sessions trying to clarify her values to increase the behavioral commitments to follow the values.

The following principles of ACT were used in the treatment sessions:

In the treatment sessions, the concept of defusion were introduced in which the client was taught to separate the obsessional thoughts from the meaning. For instance, the client's negative self-judgment was "No one likes me" was modified to of "I'm having the thought that".

The concept of acceptance was introduced in which she was asked to make herself anxious by imagining herself in an unpleasant situation and also notice her to monitor the physiological response in which she was encouraged to accept and not to escape from the unpleasant situation.

The concept of mindfulness was introduced in the following week. The client was taught to watch her thoughts while doing the activities (E.g.: Touching and washing her husband's clothes). Slowly a concept of mindfulness was introduced to the client. She was asked to close the eyes and observe her pleasant and unpleasant thoughts while doing the tasks (E.g.: Touching her husband's clothes).

She started to discuss and clarify her values (E.g.: About relationship with others, Meaning and Purpose of her life). KA revealed that she had always found meaning and purpose in helping others and found happy.

The final session was discussed and committed to all the principles of mindfulness, accepting distress thoughts and defusing of obsessive thoughts.

Post Therapy Assessment:

In post assessment, her scores on Y-BOCS severity rating scale were found to be 15 for obsessions and compulsions respectively indicating mild level of severity.

Follow up:

Follow up sessions were conducted once a month, to avoid relapse. Three follow up sessions have been conducted till date. The Patient reported improvement in all spheres of her life including social, personal and occupational. The client reported being highly satisfied with the therapy and she is very motivated. Along with that her children reported considerable improvement in her behavior and symptoms. The client was instructed to practice graded exposure and relaxation techniques at home by herself as much as possible. Assessment was done after follow up session which was conducted after 3 months; her scores were found to be 5 and 4 for obsessions and compulsions respectively, indicative of subclinical level of severity.

Other Therapeutic Outcomes:

The application of ACT and Exposure Relaxation Prevention produced significant changes in the anxiety symptoms of patient:

- Increased optimism and increased self-efficacy.
- Started maintaining good interpersonal relationships.
- Started to understand objects of fear and to reduce her anxiety by doing relaxation exercises.
- Psychologically prepared to expose herself to any situation to which previously she was scared of.
- Insight about her illness has also improved.
- Patient's score on Y-BOCS fell from 31 to 15.

DISCUSSION:

The present case study was done to see the efficacy of Acceptance and Commitment Therapy and Graded Exposure in OCD. Implementation of ACT and ERP on the client of OCD has brought considerable and noteworthy changes within the patient. The client reported significant improvement in various areas in which earlier she was facing difficulty. The client's self-confidence and self-efficacy has also improved. In reality the person is not scared of the object but with the prospect of future outcome, which was getting contaminated in the present case. With the help of repeated real and imagined exposure to feared consequences the client was able to win over her obsessional thoughts and compulsive actions, at the same time she developed self-efficacy, in that she realized if such a situation comes in future, she would be able to tackle it without getting anxious. She is now able to touch dirty objects without being terrified about the future outcomes and remains comfortable in its presence. The client is very motivated and comes for all the follow-up sessions.

CONCLUSION:

The case study has shown that OCD could be treated effectively through ACT and ERP. The present case work up has indicated the effectiveness of ACT and ERP in treating OCD. Confirmation is needed with more patients of OCD. The efficacy of theses therapeutic techniques could be tested with other anxiety-based disorders too.

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