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INFLUENCE OF BEHAVIOR THERAPIES AND RELAXATION TECHNIQUE ON OCD

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KEYWORDS :

INTRODUCTION

Only 30–40% of people with obsessive compulsive disorder (OCD), one of the ten most incapacitating illnesses according to the WHO, seek specialized treatment. When used appropriately, the currently available pharmaceutical and psychotherapy methods are very useful Psychiatrists' limited ability to identify and treat OCD is likely due to patients' reluctance to seek professional help as well as the fact that OCD rarely occurs in circumstances that necessitate hospitalization, as indicated by multiple surveys.

These crucial problems raise the possibility that many patients may not receive appropriate care and will be incorrectly classified as resistant when many viable treatment options have not been presented. Major psychotherapies that effectively work on OCD patients are as follows

COGNITIVE BEHAVIOR THERARPY (CBT)

Cognitive Behavior Therapy (CBT) is an intervention strategy that helps in finding a solution to emotional and behavioral disturbances seen in clients by making use of their cognitive and behavioral reactions to internal stimuli and external events. This therapy is used as a strategy for the treatment of numerous mental health problems that can be applied cross-culturally. Although cognitive-behavioral intervention varies in its application and form, all of them highlight the significance of modifying behaviors and cognitions as a method to reduce symptoms and to improve the overall functioning of the affected individual.

EXPOSURE AND RESPONSE PREVENTION (ERP)

Exposure and response prevention (ERP) is a first line treatment for OCD (Koran, Simpson and Guideline Watch, 2013, American Psychiatric Association, 2010). ERP is a form of cognitive behavioral therapy (CBT) that involves providing psychoeducation to the patient, helping the patient confront fears or discomfort related to their obsessional thoughts (exposure), and having the patient resist performing compulsions (response prevention). Patients can be exposed to actual situations (in vivo exposure), imagined situations (imaginal exposure), or the physical sensations associated with anxiety or discomfort (interoceptive exposure). The goal of ERP is to challenge how a patient responds to distress and to eventually learn that feared stimuli are safe. In this review, we will discuss the theoretical background of ERP, factors related to the efficacy and effectiveness of ERP, and treatment utilization and dissemination.

Exposure and Response Prevention (ERP) is considered the most effective psychotherapeutic treatment for Obsessive-Compulsive Disorder (OCD). The literature supports its adoption yet results vary and vagueness regarding therapy protocol exists. ERP therapy developed from Meyer's (1966) ground-breaking approach which incorporated previous behaviour research (Abramowitz, 2006a) based on prolonged exposure to distressing stimuli to modify "patients expectations". Today, therapy is guided by a widely used and comprehensive treatment manual (Foa et al., 2012), developed via evidence-based research supporting necessity of: ***in vivo*** and ***imaginal*** exercises (Foa et al., 1980; Foa& Goldstein, 1978); combined exposure with response prevention (Foa et al., 1984); daily up to weekly sessions (Abramowitz, Foa, & Franklin, 2003; Foa et al., 2012); and therapist guidance (Abramowitz, 1996; Tolin et al., 2007).

Jacobson Progressive Muscl Relaxation Technique (JPMR):

This is a therapy that helps the patient to relax and tighten the muscle is a series or in a progressive way. Initially Progressive muscle relaxation was initially developed by American physician **Edmund Jacobson in 1908.** The main purpose of this technique is to reduce stress and anxiety. This is a technique that will help the patient to be calm. Even though the root cause of anxiety is not reduced, the ability to face the situations increase.

MINDFULLNESS

Mindfulness-based interventions seem suitable for treating OCD for several reasons. The meaning and significance people give to symptomatic intrusions in OCD are an important factor in causing and maintaining OCD (Rachman, 1997). Because mindfulness meditation advocates nonjudgmental awareness and acceptance of every thought, feeling, or sensation (Bishop et al., 2004), the attached significance to intrusions can be reduced by mindfulness (Baer, 2003). Of relevance, mindfulness also teaches "letting go" of bothering thoughts and feelings. Letting go may reduce the need to perform a "compensatory" compulsion related to obsessive thoughts (APA, 1994) and may decrease the risk of attaching significance, both of which could decrease OCD symptoms (Rachman, 1997).

OBSESSIVE COMPULSIVE DISORDER AND COGNITIVE BEHAVIOR THERAPY

The psychological interventions have been shown to be effective in the management of OCD since the last two to three decades (Mckay et al., 2015; Haven et al., 2015; Ost et Al., 2015, Romanelli et al., 2014; Williams et al., 2013; Fisher et al., 2005). After, the emergence of CBT intervention the prognosis of OCD has changed from poor to good (Mckay et al., 2015; Ost et al., 2015). Cognitive Therapy in CBT refers to specific methods and techniques that help to change irrational beliefs and ideas, including those prevalent in OCD.

Specifically, Behavior Therapy of CBT for OCD refers to particular processes and techniques for altering behavior like the compulsive act involved in OCD. In other words, CBT for OCD is a type of psychotherapy that employs both behavioral and cognitive therapy techniques to decrease or eliminate the symptoms of obsessions, compulsive behaviour, and extensive avoidance changing the specific core beliefs, faulty appraisals, and dysfunctional neutralization responses that are associated in the etiology and maintenance of the obsessive compulsive disorder.

Sample:

From 300 patients 60 patients are randomly selected. They include both men and women, married and unmarried, with educational qualifications ranging from undergraduates to graduates with different levels of socio economic status constituted the sample of the study.

Tools:

1. Yale-Brown Obsessive Compulsive Scale (YBOCS) developed by Goodman et al. (1989)
2. Yale Brown OCD Symptom Check list

Table 1 : Paired t-test : Pre test and Post test Difference in SEVERITY of OCD

Sl.NO	Variables	Pre test			Post test			t-value	p value
		N	Mean	S.D	N	Mean	S.D		
1	YBOCS Obsessions	60	16.85	3.76	60	3.22	2.54	38.940**	0.000

2	YBOCS Compulsions	60	15.97	3.73	60	2.23	2.68	32.548**	0.000
3	YBOCS Total	60	32.82	6.20	60	5.45	4.56	43.302**	0.000

Table 2 : Pre test and Post test scores on symptoms of Obsessions

Sl.NO	Components	Pre test			Post test			t-value	p value
		N	Mean	S.D	N	Mean	S.D		
1	Aggressive Obsessions	60	3.33	2.00	60	0.55	0.75	12.008**	0.000
2	Contamination Obsession	60	3.62	2.16	60	0.57	0.79	11.742**	0.000
3	Sexual Obsession	60	0.63	0.88	60	0.23	0.43	3.288**	0.002
4	Hoarding or Saving Obsessions	60	0.58	0.62	60	0.17	0.38	4.483**	0.000
5	Religious Obsessions	60	1.00	0.71	60	0.20	0.44	7.762**	0.000
6	Obsessions with need for Symmetry or Exactness	60	0.75	0.91	60	0.25	0.47	3.748**	0.000
7	Miscellaneous Obsessions	60	3.10	2.58	60	0.57	1.02	9.331**	0.000
8	Somatic Obsessions	60	0.63	0.74	60	0.20	0.44	3.771**	0.000
9	Total Obsessions	60	13.65	5.84	60	2.35	2.10	16.509**	0.000

Table 3 : Pre test and Post test scores on symptoms of Compulsions

Sl.NO	Variables	Pre test			Post test			t-value	p value
		N	Mean	S.D	N	Mean	S.D		
1	Cleaning Compulsions	60	1.55	1.17	60	0.20	0.48	8.782**	0.000
2	Checking Compulsions	60	2.58	2.20	60	0.45	0.70	8.781**	0.000
3	Repeating Rituals	60	1.05	0.93	60	0.17	0.49	7.734**	0.000
4	Counting Compulsions	60	0.46	0.19	60	0.536	0.39	3.132**	0.003
5	Ordering or Arranging Compulsions	60	0.40	0.53	60	0.18	0.39	2.621*	0.011
6	Hoarding Compulsions	60	0.4	0.53	60	0.22	0.42	2.381*	0.200
7	Miscellaneous Compulsions	60	2.02	0.63	60	1.672	0.71	7.771**	0.000
	Total Compulsions	60	8.45	2.43	60	4.248	2.06	11.66**	0.000

PROCEDURE:

After seeking required permission from hospital authorities and participants, Participants were diagnosed with OCD according to the ICD 10 criteria. Participants were given information about the study and presented with the option of taking part. Written consent was received by all persons choosing to participate in the study. Participants were administered YBCOS rating scale and Symptoms Checklist before starting the interventions and this constitute pre-test score on OCD. Then CBT is given for about 10 sessions each of 45-60 mins, ERP 10 sessions each 45 mins, JPMR 1-2 sessions 60 mins and mindfulness one session 30 mins. After completing the intervention sessions, participants were administered YBCOS rating scale and Symptoms Checklist .This constitutes the post test scores of OCD. Booster sessions were given if needed.

RESULTS:

An observation of Table-1 shows that the mean value is 16.85 and SD 3.76 in pre-test for obsessions and 3.22 and 2.54 on post-test respectively . There is a phenomenal decrease in the severity of obsessions. The t-value of 38.940 is significant beyond 0.01 level suggesting that there is significant reduction in the severity of obsessions. With regard to compulsions the mean value is 15.97 and SD 3.73 in pre-test and after intervention the mean value is 2.23 and SD 2.68. The t-value of 32.548 is significant at 0.01 level suggesting that it has significantly reduced the severity of compulsions attributing to the administration of Behaviour therapies and relaxation techniques.

Table – 2 presents means and SDs of scores on various components of obsessions and t-values. A closed observation of the table 2 reveals that all the t-values for various components are significant beyond 0.01 level. It indicates that the intervention program is highly effective in reducing the symptoms of various components of obsessions.

Table 3 presents the means and SDs of scores on various components of compulsions and corresponding t-values. Here also all that values are significant suggesting that intervention programs have significantly reduced the symptoms of various compulsions. The intervention programs are highly effective in reducing the symptoms of various compulsions.

CONCLUSIONS:

1. Behaviour therapies and relaxation techniques have significantly reduced the various symptoms of Obsessions and its severity

2. Behaviour therapies and relaxation techniques have significantly reduced the various symptoms of Compulsion and its severity

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