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Mindfulness Based Psychotherapy In Obsessive Compulsive Disorder A Case Report

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Abstract: ***The aim of the current paper is to examine the efficacy of Mindfulness based psychotherapy in reducing negative emotional states like anxiety, depression, modifying negative cognitions, compulsions and to improve day to day functioning.***

The essential feature of Obsessive Compulsive Disorder (OCD) is recurrent obsessions or compulsions sufficiently severe to cause marked distress to the person .The obsessions or compulsions are time consuming behaviors causing marked social, obsessions or compulsions sufficiently severe to cause marked distress to the person's personal, family and occupational dysfunctions. The lifetime prevalence of OCD in general population is estimated to be 2-3 percent. Some research have investigated that this disorder is found in as many as 10 percent of out patient clinics. It makes the OCD the fourth most common psychiatric disorder. Its mean age of onset is about 20 years, although men have slightly earlier age of onset. Patients with obsessive compulsive disorder tend to respond to medication with only a 30-60% improvement in symptoms and tended to remain chronically symptomatic to some degree. In recent years, pharmacotherapy and psychological interventions in combination have become the practice and are found to be more effective. The present case report attempts to highlight the effect of mindfulness based psychothereutic interventions and pharmacotherapy on a patient with OCD. The patient was non responsive to pharmacotherpetiuc interventions, however, the combined treatment resulted in significant improvement.

Method: A single case design was adopted for the current clinical work. Female client with a diagnosis of Obsessive Compulsive Disorder with an age of 35 years fluent in Hindi was given 19 approximately one hour sessions of Mindfulness based Psychotherapy spread over 4 weeks. The sessions were planned almost everyday. Pre and post therapy assessment was carried out using Yale Brown Obsessive Compulsive Scale (Y-BOCS) and Beck Depression Inventory (BDI).

Result & Discussion: Individual case analysis indicated significant improvement in OCD symptoms on Y-BOCS and depressive symptoms on BDI. Clinical report indicated 25% improvement in anxiety and improvement in day to day functioning.

Keywords: OCD, psychotherapy, mindfulness

I. INTRODUCTION

The essential feature of Obsessive Compulsive Disorder (OCD) is recurrent obsessions or compulsions sufficiently severe to cause marked distress to the person .The obsessions or compulsions are time consuming behaviors causing marked social, obsessions or compulsions sufficiently severe to cause marked distress to the person's personal, family and occupational dysfunctions. The lifetime prevalence of OCD in general population is estimated to be 2-3 percent. Some research have investigated that this disorder is found in as many as 10 percent of out patient clinics. It making the OCD the fourth most common psychiatric disorder. Its mean age of

onset is about 20 years, although men have slightly earlier age of onset.

Treatment modalities include pharmacological as well psychotherapies. In pharmacotherapy, tricyclic antidepressants, clomipramine and in selective serotonin reuptake inhibitors (SSRIs), fluoxetine, fluvoxetine, sertraline and paroxetine are widely used. Behavioral interventions, cognitive behavior therapy and recently mindfulness based cognitive behavior therapy have become the major focus in psychotherapeutic interventions.

Patients presenting with OCD continue to present a considerable challenge to the therapist, perhaps more so than most of the other anxiety disorders so far. Cognitive behavior therapy that includes exposure and response prevention and cognitive restructuring is the recommended first line treatment either by itself or in combination with pharmacotherapy. Salkovski's cognitive behavioral model (1985; 1989) of OCD places appraised responsibility associated with intrusive thoughts in a pivotal role. Moreover, the OCD patient's neutralizing and thought control strategies are viewed as central in maintaining the symptoms since they terminate exposure and exacerbate intrusions building on the concept of responsibility appraisals (Rachman, 1973)

In the last 25 years, mindfulness and interventions based on it has become the focus of considerable attention for a large community of clinicians and researchers. Mindfulness has been described as a process of bringing a certain quality of attention to moment-by-moment experience (Kabat-Zinn, 1990). Mindfulness in contemporary psychology has been adopted as an approach for increasing awareness and responding skillfully to mental process that contribute to emotional distress and maladaptive behaviors in the form of symptoms. Much of the interest in the clinical applications of mindfulness has been sparked by the introduction of Mindfulness-Based Stress Reduction (MBSR), a manualizedf treatment program originally developed for the management of chronic pain (Kabat-Zinn, 1982). Segal, Williams and Teasdale (2002) developed Mindfulness-Based Cognitive Therapy (MBCT) a relapse prevention program in depression and has been useful in the management of OCD also.MBCT integrates mindfulness with the emphasis of treatment on acceptance, change, integrating spiritual component of mindfulness into traditional cognitive behavior therapies (Hayes, 2004).

II. CASE SUMMARY AND MSE

A.P, 35 year old married Hindu female, studied upto Vth standard, a home maker, hails from Chattisgarh, belonging to middle socio-economic status urban background presented with family history of OCD in elder sister and MR in maternal niece with medical history of hypertension in sister, with significant past history of hypothyroidism for 18 years, diabetes mellitus for 3-4 years and tubectomy and ovariectomy done 10 years ago with personal history of polymenorrhoea now controlled, premorbidly having anakastic traits of orderliness, cleanliness, perfectionism. She was presented with 12 years history of continuous illness with insidious onset and progressive course characterized by repeated leg and hand washing, repeatedly taking bath, forcing others to take bath as she feels they are dirty and with three episodes of DSH of high intentionality and lethality with impulsive act.

MSE revealed obsessive doubt of contamination, and compulsive hand and leg washing and bathing excessively (7-8 time/ daily). The diagnosis made was OCD mixed.

III. CLINICAL ASSESSMENT AND THERAPY SESSIONS SUMMARY

BEHAVIOURAL ANALYSIS

Behavioural analysis was done in the first two sessions. It is as follows:

INITIAL ANALYSIS OF THE PROBLEM SITUATION

- ✓ Behavioral excesses in terms of frequency, intensity and duration were found to be excessive hand, leg and face washing 10-14 times a day. Taking long time to take bath 1-2 hours, around 2-3 times a day. Excessive thoughts about contamination, avoiding dome toilet, this lead to taking bath only in her room.
- ✓ Behavioural deficits were found to be not touching and using comboard.

Client's behavioral excess and deficits significantly impaired her daily functioning. She started taking bath in her room, did not do household work and kept a maid to carryout household activities.

CLARIFICATION OF THE PROBLEM SITUATION

Antecedent events and triggers that lead to problem behaviours were seeing the dustbin, hearing about pigs, seeing dogs feces on road and thinking of toilet. These would create negative cognition like "I will not be able to sleep", "I have become dirty", "I won't touch anything", which in turn lead to anxiety and leading client to neutralizing behaviors like hand washing, leg washing. This vicious circle would go on.

The consequences that occurred to the client and significant others due to problem behaviour were

- ✓ Significant impairment in social and household functioning. She could not take bath in bathroom, would take bath only in her room, started defecating in the room and did not go to toilets, wasn't able to do any household work and kept a maid for doing that.
- ✓ Frequent conflict with the husband. Expressed emotion in the family increased. The husband become very critical and hostile to the client. On one occasion, the client slit her wrist in response to husband's critical comments and remarks. Husband's own anxiety and panic was also contributing to the client's problem behaviours. She was not able to take care of her children at all. Besides, the client was stigmatized and was completely socially isolated.

MOTIVATIONAL ANALYSIS

Client's negative schemas that "I should be clean", her avoidance of situations like going to bathroom, toilet and beliefs that she has to wash and increased husband's criticality have been maintaining her problem behaviors. Husband's yielding to client's proxy compulsion would be reinforcing her problem behaviors. Three major aversive stimuli for client in her day to day life situation were seeing and thinking about toilets, seeing contaminated places and dog faces.

DEVELOPMENTAL ANALYSIS

The client has personal history of hypothyroidism for the last 18 years which has not been successfully treated and has also been contributing to client's current anxiety symptom, she has undergone tubectomy and ovariactomy done 10 years ago, and has been having diabetes mellitus for the last 3-4 years for which she has been taking tablets and on dietary management. Besides, the client has dysmonnrohea which has lead to client missing some therapy sessions.

SOCIOLOGICAL CHANGES

After the onset of the client's illness, the husband has become quite critical toward her and even blame her for not putting her best effort in treatment procedures. The husband's over involvement has made the client too much dependent on him and developed a passive attitude in the client. The onset of illness has stigmatized the family and their social interaction with relatives, neighbours and friends has significantly decreased. In a way the client and the whole family has been socially isolated.

BEHAVIORAL CHANGES

Premorbidly the client was described as being perfectionist, and too much concerned about orderliness and cleanliness.

COGNITIVE – BEHAVIOURAL FORMULATION

The client has a family history of psychiatric illness (OCD) in the elder sister which might be a predisposing factor. Premorbidly the client was having anankastic traits like perfectionism, orderliness and cleanliness. Presence of elder sister having OCD characterized by repeated hand washing and avoidance of contaminated place would act as model for the client. Her modeling of her sister would led to the formation of her cognitive schemas like "I should be clean", "I should be perfect". The client's seeing people defecating in public actually precipitated the client's symptom. The thoughts of dog's feces, thinking about bathroom and toilet, and even seeing people coming to the room with sleepers would activate her already formed schemas that would appraised by her as being disgusting and threatening and she used ritualistic behaviours like repeated hand washing to reduce her anxiety hence these symptoms are further negatively reinforced along with this husband's yielding of her proxy compulsions are all acting as maintaining factors and hence are maintaining about symptoms through vicious circle. Besides these, significant negative life events like ovarictomy, tubectomy and diabetes mellitus might also have maintained the current symptoms.

PLAN OF ASSESSMENT

Clinical assessment of the patient revealed that the major symptoms need to targeted were as follows

- ✓ Repetitive thoughts of being dirty and that I that should be clean
- ✓ Repetitive hand washing and taking bath.
- ✓ Reducing the time taken for bathing
- ✓ Increasing functional activities of the client

In order to have comprehensive evaluation of the patient's symptoms and understanding symptoms severity and functioning of the patient, the following tools were used.

- ✓ *Y-BOCS SYMPTOM CHECKLIST*

The significant symptoms revealed through the checklist were "*Concerns or disgust with bodily waste or section, Concern with dirt or germs &Excessive concern with environmental contaminants.*

- ✓ *Y-BOCS SYMPTOMS SEVERITY*

Time occupied by obsessive thoughts revealed was approximately 3-8 hours leading to severe impairment in socio-occupational functioning. Compulsive behaviors in the form repetitive hand washing, bathing and washing other body parts as revealed through symptom severity scale was around 8 hours leading to severe impairment in her day to socio-occupational functioning.

- ✓ *BECK DEPRESSION INVENTORY (BDI)*

Since depression is often a co morbid condition secondary to OCD, BDI was used to evaluate severity of symptoms of depression (if depression is present). *BDI score was 22* indicating moderate depression with main symptoms being *feeling guilty* (score 2) *suicidal thoughts* (score 2) *loss of interest* (score 2) and *punishment feelings* (score 3).

TREATMENT MODALITIES PLANNED

- ✓ EXPOSURE AND RESPONSE PREVENTION

Exposure and response prevention is one of the anxiety induction techniques which is primarily used in the treatment of OCD, ERP includes

- Prolonged exposure of the stimulus (i) which is aversive to the client and
- Strict ritual prevention following the exposure.

Before starting ERP, hierarchy is made by the client of stimulus (i) which are causing distress to her/him and rate the anxiety being produced on 0-10 scale. Then the stimulus (i) are presented in graded fashion from the least anxiety producing to the most anxiety producing ones. ERP works on the principle of

habituation and extinction. ERP is considered as main component of treatment modality as the client has been avoiding some of the situations like going to toilets, contaminated places and roads where dog feces were presented which were causing significant impairment in her social role functioning. With the exposure, response prevention was also utilized so that the client learned to tolerate anxiety were subsequently lead to decrease anxiety symptoms.

✓ *COGNITIVE RESTRUCTURING*

Cognitive restructuring is a process in which cognitive distortions or dysfunctional beliefs which are leading to the problems are corrected. Through behavioural analysis it was found that the client was having dysfunctional beliefs like "I should be clean always", "I should be perfect", so cognitive restructuring strategy was planned to correct her negative cognitions and make her thoughts more realistic and rational.

✓ *MINDFULNESS*

Mindfulness has been described as "bringing one's complete attention to the present experience on a moment-to-moment basis" and as "Paying attention in a particular way: on purpose, in the present moment and non judgmentally. Mindfulness was primarily used as a relapse prevention strategy for the client.

DETAILS OF SESSION

Including assessment sessions, total nineteen sessions were conducted. Each session was of one hour duration and the session was conducted almost every day in the Department of Clinical Psychology of the hospital.

In the first session working alliance was developed with the client and the husband and both were psycho educated about the illness, causes of OCD, myths related to it, interventions following biopsychosocial model and importance of compliance and medical adherence factors. In the second session psycho education about the OCD was completed and she was encouraged to spend time as much as possible talking with people or things which she finds interesting. The patient and the husband were informed that the next session will focus on psychological evaluation to understand her symptoms in more detail. Along with that, the client and the husband were told by the therapist that psychological treatment for OCD will start after psychological evaluation is completed based on evaluation findings and clinical report of the patient. Goals for the therapy will be planned after mutual discussion between the patient and the therapist. Having completed the evaluation and goal setting process (Cleaning, washing compulsions), the therapy started after two evaluation sessions and goal setting process. In the next two sessions the client was told about ERP, the rationale of using it, and client's consent was taken before starting the treatment. The client and the husband both were told that ERP involves inducing anxiety in the client which is normal and in fact essential component of the treatment. Initially the client will experience high anxiety but slowly it will decrease across sessions. She was clearly told that she need to tolerate anxiety during the treatment. The principle of extinction and habituation was explained to her by giving an example of a child who fears darkness and how his darkness fear can be reduced through repeatedly exposing the child to the darkness.

Client was asked to prepare a list of stimuli which has been causing anxiety to her. After the list was made, she was asked to rate stimuli in terms of most anxiety producing and least anxiety producing on 0-10 scale, 0 being least anxiety producing and 10- most anxiety producing. She was told that the therapy will start taking the least anxiety situation and slowly to the increasing anxiety situations. For example "crossing the road with dog feces", was described as least anxiety producing on anxiety producing last, then "going to public toilets", and "visiting contaminated plans" etc. the therapy was started by asking the client to came through the road where the dog's feces were present. In the initial sessions the client was reluctant to come through that road but however was able to come and reported feeling anxious. This was continued for 4-5 sessions. From the fifth session, the target set was visiting of public toilet. The client was told to visit the public toilet in academic section. She was told she had to go and remain there, the anxiety that she would experience, she just need to tolerate that and she was reassured that no aversive event will take place as all staff and others are visiting the toilet. Initially she was reluctant to go to the toilet but on motivating and reassuring her by the therapist and the husband she could go to the toilet. The patient remained inside the toilet for around 10 minutes and then came out saying that she couldn't tolerate the smell inside it. But she was appreciated and reinforced by the therapist for putting her efforts and going and experiencing anxiety. She was however told that in toilets there would be bad smell but the purpose is to help her started going and using public toilets and toilets in general to make her life more functional. For the next two sessions, the client remained in the toilet for 10-12 minutes but she explained that she did not feel as much anxious as in the initial exposures. Besides that, the client was also told in all ERP session that after going back to hospital ward she should not take bath. She reported an urge to take bath but was able to control. She was appreciated for that. However at times she would take bath in the wards following exposures. In these sessions, the plan of making the client more functional was also discussed. She was asked to involve herself in small activities like making tea, washing utensils and clothes to the extent possible. The client was able to follow activity scheduling to some extent in the ward. From the VIth and VIIth ERP session, the client was asked by the therapist to visit places like city market, railway station which has been avoiding. It was again told that the client should not take bath after visiting these places. However she can wash her feet and hands once. She was also told not to force husband to take bath as she was doing at home. In this way 10 sessions were done on ERP. Focusing on coming from roads where dogs feces were there, visiting public toilet, city market, railway station and not taking bath after visiting these places and not forcing the husband to bath. Though the client was regular and punctual in session and timing, inconsistency was reported by the husband and noticed by the therapist too in following husband's monitored ERP. It was also noticed in the sessions

that the husband was over involved and very sticky and the therapist in each of the sessions psycho-educated the husband about the importance of not being over involved. He was also told to help client becoming more active and independent. Though inconsistency was reported even by the client in following ERP being monitored by husband and at times taking bath after coming from sessions. Yet she reported 40% improvement in anxiety in using public toilets, and visiting contaminated places like city place, and railway station. In each of the sessions, the client was asked by the therapist to elaborate the belief associated with avoiding the anxiety producing stimuli mentioned by the client. But she could not elaborate on her associated beliefs with her ritualistic behaviors like excessive bathing.

From the XI session, mindfulness was started as relapse prevention strategy. She was educated about mindfulness, its rationale and utility in OCD in her case. Mindfulness was done for 15-20 minutes, and could understand it and follow it. However visiting public toilets, and contaminated places continued. She learned mindfulness in 4 sessions and from 15th session onward she could do it on her own. She was also doing mindfulness in the ward as told by the therapist for 15-20 minutes.

The last 3 session (17-19) focused on relapse prevention and post assessment. Relapse prevention was focused on reemphasis on following husband's monitored ERP, trying to be as functional as possible. The client was told that she needs to put her best effort possible, continue to take medicine regularly, doing household work as much as possible, the husband was also told not to be overly involved and being critical and help her in making the client independent and functional. The client reported 20% improvement in her subjective anxiety and also reported the husband that she does not force him to take bath. She was able to go to public toilets and visit contaminated places, but continue to report on urge to take bath every time she visited these places. Se was instructed that whenever she feels anxiety she has to do mindfulness.

The 19th session was post assessment session on Y-Bocs Symtom checklist, symptom severity and BDI. *Concerns or disgust with bodily waste or section*, *Concern with dirt or germs* & *Excessive concern with environmental contaminants* were reduced to around 2 hours and the patient reported 25% improvement in these symptoms. On BDI, post therapy score dipped to 12 dropping depression from moderate to mid category.

Husband was also told not to load stress on the client like forcing her to do things rather he was told to encourage whatever she can do. As planned cognitive restructuring could not be done as the client was too passive and not coming forth about her cognition.

CBT work could not be done with the client as she was not coming with her associated beliefs and overwhelmed by her anxiety. So behavioral measures were considered only as treatment modality.

IV. CONCLUSION AND THERAPY OUTCOME AND FOLLOW UP

- ✓ After the therapy sessions, the client reported 20-30% improvement in her symptom in the form of decrease time taken in bathing (2 hrs to 20 minutes approximately). She started visiting public toilet, passing through roads where dog feces were present which she has been avoiding earlier.
- ✓ She reported decrease in anxiety which she was subjectively feeling. She had stopped forcing husband to wash hand and take bath. Her repeated hand and leg washing was also reduced.
- ✓ Follow-up was planned after 6 months. Once husband telephoned and reported that though she improved but continue to have symptoms at time like avoiding going to bathroom, forcing husband to wash hands.
- ✓ The client also reported that once she slited the wrist when the husband became too critical and physically beat here. They were told to continue focus on husband's monitored ERP, regular in taking medicines and reduce criticality in the family.

V. RESULT & DISCUSSION

The treatment of OCD is usually more complicated than the treatment of other anxiety disorders. Under the situation with affective disorder, OCD patients respond to medicine with only 30% to 60% symptoms reduction and the patient tend to remain chronically sympotomatic (Jenike, 1992). In recent years, SSRIs and psychotherapeutic interventions have become the major treatment modalities. Pharmacotherapy provides symptoms relief, however, the psychotherapy not only provides symptom relief but also useful in long term management, in chronic cases, increase medical adherence, decreases the chances of relapse and improve overall quality of life. This case highlights the role of psychotherapy in the management of OCD. Behavior techniques like activity scheduling, ERP and reinforcement were useful in normalizing the day to day activities; mindfulness was effective in reducing the anxiety.

To conclude, the present case demonstrates clinically the efficacy of mindfulness based psychotherapy along with pharmacotherapy in a patient with OCD. There is, however, need to carry out empirical work on large samples using Randomized control designs. Long term follow up would be required to evaluate the efficacy of psychosocial interventions.

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