

# Cognitive Behavior Therapy (CBT) Selective Treatment for Obsessive Compulsive Disorder (OCD)

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## ABSTRACT

Obsession- compulsive disorder is one of the common anxiety disorders. Not in a far past, it was mistaken with some of serious illnesses such as schizophrenia or psychosis and it was thought to be treatment-refractory. Fortunately, with the recognition of the behavioral techniques of exposure and response prevention and CBT approach, this insidious condition has changed from a resistant condition into a condition with available effective, various treatment options, pharmacotherapy, and psychotherapy. In its severe manifestations, it is often a torturous and debilitating disorder. Based on the DSM-IV-IR (American Psychiatric Association 2000), obsessions are defined as repetitive and persistent thoughts, impulses or images that a person experiences. After the treatment, especially pharmacotherapy, usually it is highly possible that this disorder relapse; unless the patient becomes familiar with the disorder and its process and the thoughts related to it and by the use of cognitive methods prevents its relapse.

Cognitive- behavior therapy is the most useable and efficacious treatment for this disorder that is applicable by the patient's help and the possibility of relapse in this method is lower than the other treatment methods especially pharmacotherapy.

In this research two methods of treatment, pharmacotherapy and cognitive –behavior therapy have been used on Iranian women with obsession- compulsive disorder and the obtained results will be brought out in the following article.

**KEY WORDS:** Obsessive-compulsive disorder, Cognitive-behavior therapy, psychopharmacology interventions.

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## BACKGROUND

### Description of the intervention

Obsessive –compulsive disorders (OCD) was, until the middle of the 1960s, thought to be treatment-refractory. It was also not unusual to mistake it or misclassify it as something much more serious, such as schizophrenia or psychosis.(1) Fortunately, since then, the behavioral techniques of exposure and response prevention, a CBT approach with now-established efficacy for reducing OCD symptoms, was being developed by Victor Meyer(1966) and Meyer and Chesser (1970). Since then, this insidious condition has graduated from an intractable, refractory condition to a condition with multiple, efficacious treatment options available, including both psychotherapy and pharmacotherapy (Bearand Minchiello, 1998, Bejerot, 1999, Foaand Emmelkamp, 1983, Koran, 1999, Steketee and Tynes, 1991, Windstorm, 1998). (2)

### Description of the intervention

OCD is now considered a commonly occurring anxiety disorder, with estimates in general population ranging from 0.05% to between 2% and 3% (Bejerot,1998;Jenike, Baer, and Minchiello, 1998;Koran, 1999;Kozak, Liebowitz ,and Foa,2000).In its more sever manifestations, it is often a debilitating and excruciating disorder ,wherein the patient suffers tremendous difficulties in multiple life areas ( e.g., occupational, social ,interpersonal ).(3) Based on the DSM-IV-TR (American Psychiatric Association, 2000), obsessions are defined as: “recurrent and persistent thoughts, impulses, or images that are experienced, at some time during the disturbance, as intrusive and inappropriate and that cause marked anxiety or distress” (p.457). For example, an obsession could be a parent having repeated thoughts about killing a child. Additionally, the thoughts, impulses, and images are not excessive worries about real-life problems; instead, they are ego-dystonic. The content may be viewed as foreign or alien and outside of the person's control; in other words, these signs, symptoms, or experiences are uncomfortable or unwanted (e.g., Lindkvist, 1999). Experiencing thoughts, for example, about personal finances may in fact be useful and be seen as adaptive and as self-generated; however, having thoughts of impulsively plunging a kitchen knife into another person would probably be unhelpful and unwanted.(4)

Compulsions are defined as “repetitive behaviors or mental acts that the person feels driven to perform in response to an obsession, or according to rules that must be applied rigidly” (DSM-IV-TR; American Psychiatrist Association, 2000, p.457). Examples of compulsions may include, but are not

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limited to, hand washing, ordering and arranging, checking, praying, counting, or repeating words silently. These behaviors and mental acts are designed to neutralize, prevent, or reduce discomfort of some dreaded event or situation, but either the activity, whether overt or covert, is not connected in a realistic way with what it is designed to neutralize or prevent or it is clearly excessive. For example, a person washing his or her hands until they are raw and cracking would illustrate this excessive response to distress. (5)

From the description of obsessions and compulsions, it may not be immediately clear how serious and incapacitating these problems can be. Rachman and Hodgson (1980a, 1980b) poignantly commented that without the experiences of people who suffer with these difficulties, it might indeed be difficult to imagine how a persistent urge to check the security of one's home before leaving for work each day could grow to such a magnitude that it impaired the individual's entire life.(6) Equally unimaginable might be how someone who is troubled by intrusive, unacceptable thoughts suffers, and how it can reach such proportions as to imprison the person and prevent him or her from carrying out constructive work, or maintaining interpersonal relationships. In its extreme forms- an intense fear of dirt and disease, for example- it could lead to moving to a new house every 6 months and eventually to even avoiding whole regions of the country. It would indeed be a mistake to underestimate the intensity and extent of suffering involved with OCD. On the one hand, it might not manifest itself in more ways than what to the onlooker appears to be idiosyncratic, curious eccentricities. On the other hand, in its more extreme forms, it can become truly incapacitating, in which the simplest chore, such as washing hands, might consume half a day or more (Hersen and Bellack, 1999).(7)

It is not uncommon to find that OCD symptoms eventually spread, surreptitiously, to the patient's social, occupational, and family life (Jenike et al., 1998). In this fashion, extensive rituals and avoidance eventually interfere significantly with daily life (Salkovskis, Richards, and Forrester, 2000). Indeed, OCD patients do report substantial social and work dysfunction, and they are almost four times as likely to be unemployed than the general population (Franklin, Abramowitz, Kozak, Levitt, and Foa, 2000). They also appear to be more likely to never marry (Steketee and Pruyne, 1998). (8)

### **Why it is important to do this review**

It seems that when the patients with OCD undergo the pharmacotherapy, disregard their own roles in the recovery and become dependent on drugs to have a less distressful life. After the course of taking the drugs prolongs, this question comes forward that whether I should take these drugs forever and if the life will be difficult without them. Particularly, this is more noticeable about those women, who are housewives, don't have a job and belong to poor families. They get into trouble and their anxiety increases. As their anxiety increases, the doctor has to increase the dose of the drug in order to control the disorder. In this case, it seems that a difficult and problematic cycle emerges and the course of drug taking prolongs, the hopelessness feeling overcomes as a result of increased depression and anxiety. Thus, the dose of the drug goes up, and causes financial problem for the patient and her family. Consequently, the treatment course becomes longer. But if there is a treatment, which of course it is, they would have a contribution in their own recovery by activating their own roles and having little reliance on the drugs. (9)

Cognitive-behavior therapy (CBT) is recommended as the psychotherapeutic treatment of choice for children and adults with obsessive-compulsive disorder (AACAP1998, March1997). (10)

In this method of treatment, the patient can discover the process of the disorder, its function, and continuation by the cognitive-behavior therapist's help. The patient can recognize the previous ineffective confrontation methods and can meet with them in a critical way. The classic forms of challenging with fear are avoidance and escape. These two usually cause the resistance of fear instead of decreasing it. During the cognitive-behavior therapy it is taught to the patients that leave these two classic methods and remain in the frightening situation until the habituation happens. They learn that anxiety increases (at the beginning of the treatment) to some extent and then decreases. Because of hedonistic principles, they can be quite unhappy and appear hypersensitive to the treatment. For fear to subside, it is necessary to face repeatedly with exactly what they fear. Facing one's fears is paramount and absolutely necessary for anxiety to remit.

Relying on this technique, this study has been done on Iranian women with OCD.

### **Objectives**

The overall aim of this review was to examine the efficacy of CBT in women with OCD in comparison to psychopharmacological intervention. The review aimed to address the following questions:

- 1- Is CBT superior to psychopharmacological intervention?
- 2- Which treatment are the patients more satisfied with?

- 3- Does CBT decrease the irrational beliefs and perfectionism?
- 4- In which treatment the rate of relapse is higher?
- 5- Which method of treatment increases the coping skills?

**METHODS**

**Criteria for considering studies for the review**

**Type of study**

This study is of experimental kind in which patients have been selected randomly and divided into two groups. In general 100 patients were studied. Every group consisted of 50 patients who were referring to the mental health centers and counseling centers. One group underwent the psychopharmacological treatment and the other group received the cognitive-behavior therapy.

**Type of interventions**

The group that received the CBT was exposed to the frightening situations and confronted with them instead of avoidance and escape of them (the situations) in the mentioned centers. The exposure work started with the systematic development of a fear hierarchy of real-life situations that they confronted with them every week. Some of the other CBT techniques that they learned through the treatment include habituation training, thought challenging, thought monitoring, relaxation , cognition training , systematic desensitization , cognitive instructing. The other group came to the centers and only received the drugs every month and took them. Before the commencement of the treatment all of the patients were assessed by the following instruments:

**1-The SCL-90-R** is a revised version of the original SCL-90. It is used as a screening measure of general psychiatric symptomatology (Buckelew et al. 1988). It includes dimensions measuring somatization, obsessive-compulsive, depression, anxiety, phobic anxiety, hostility, interpersonal sensitivity, paranoid ideation, and psychoticism.

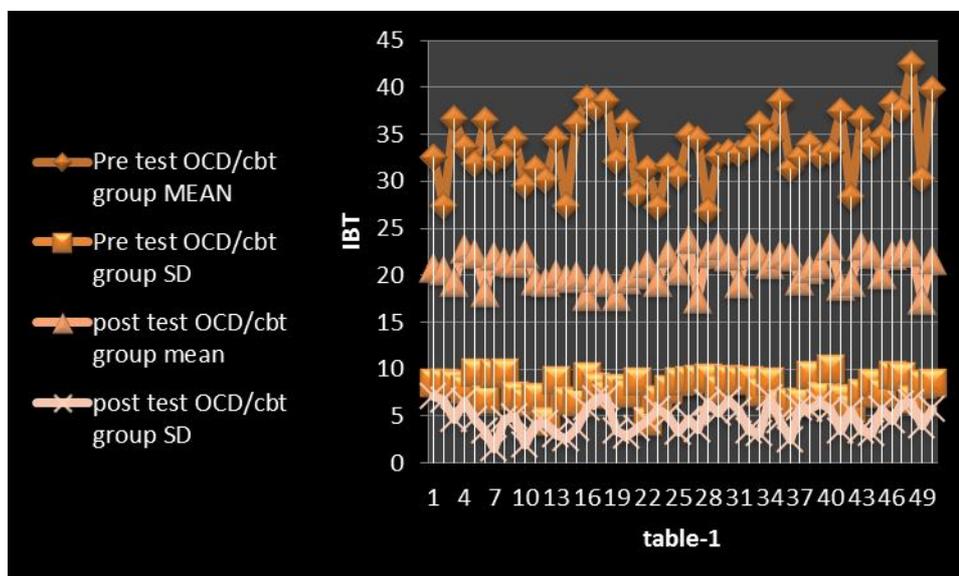
**2-Jones' (1968) Irrational Beliefs Test (IBT)** is a prominent self-report instrument that assesses dispositional rationality-irrationality with respect to 10 beliefs proposed by Ellis.

Irrational Beliefs Test (IBT). Jones developed the 100-item IBT which requires respondents to indicate their level of agreement or disagreement with each of the items on a 5-point scale. Half of the items indicate the presence of a particular irrational belief, the other half its absence. Lohr and Parkinson reported that the IBT demonstrated positive correlation with measures of anxiety and depression. Whereas the IBT initially was one of the most popular measures of irrational beliefs, its use has gradually diminished due to criticisms that these beliefs were not measured independently of the emotional consequences they were hypothesized to cause. Nonetheless; it still sees occasional use (see Munoz- Eguileta. Woods argued that a modified IBT could be useful; he identified 47 IBT items that measured beliefs and found that these items were related to emotional distress, psychosomatic symptoms, and suicidal contemplation).

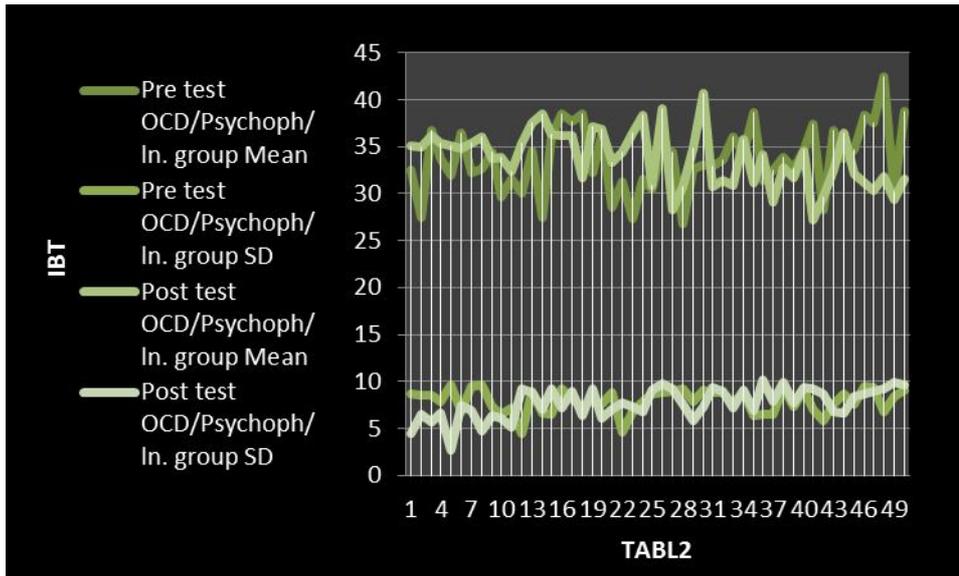
3- Interview diagnosis according to DSMIV-TR.

4- Treatment consent inventory (at the end of course of treatment).

The course of CBT was 12-16 sessions, but the course of psychopharmacological treatment was at least six months. At the end of the treatment, both of the groups were assessed again by the above instruments.

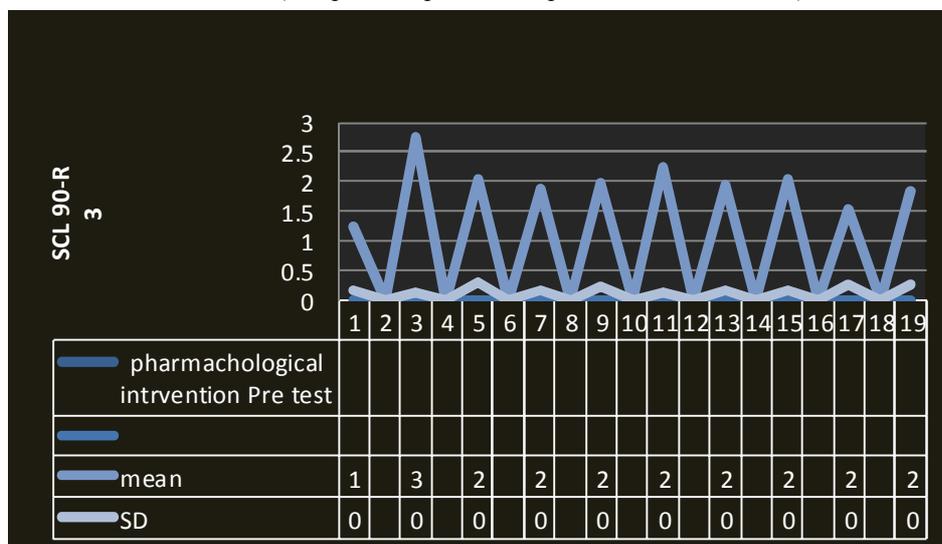


**table-1**

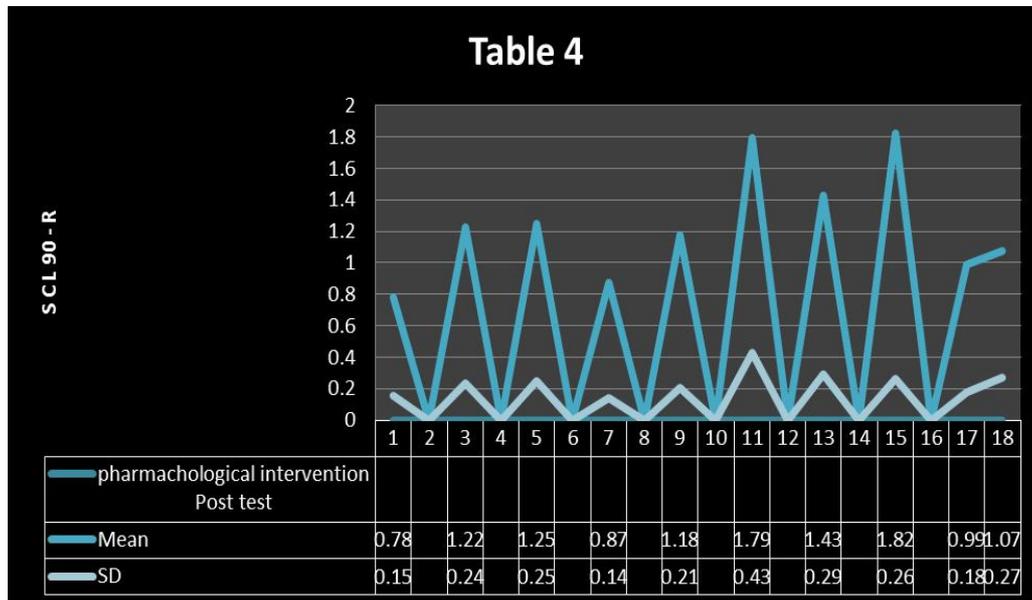


**RESULT AND CONCLUSION**

- 1- At the end of the treatment, the group who just received the psychopharmacological treatment was unwilling to the continuation of treatment and fear of being dependent on the drugs was one of their complaints, and as it is seen their irrational beliefs in comparison with CBT group did not change. (table 2)
- 2- Their repetitive behaviors and ritual doing had been decreased less than the other group with CBT. They said that they couldn't stop doing some of the repetitive behaviors.
- 3- Psychopharmacological treatment also like CBT decreased their depression and anxiety.(see table 3 , 4)
- 4- Psychopharmacological treatment had no effect on their irrational beliefs. (see table 2)
- 5- CBT had decreased their irrational beliefs.(table 1)
- 6- The treated patients with CBT didn't seek the confirmed reassurance and could better prevent their repetitive behaviors.
- 7- They had tendency toward the continuation of the treatment and were more satisfied with the obtained success more than the other group.
- 8- Basically the CBT has been designed for anxiety disorders (Beck and colleagues) and as mentioned its applicability for the treatment of OCD was recommended to the field related practitioners. Our study also shows that CBT in comparison to the psychopharmacological treatment is more effective. (compare the pretest and posttest in table 1,2,3,4)



In addition, CBT makes the patients feel self-worth and this reduces anxiety and depression per se. Through CBT, patients could develop some skills that thereafter they can use them in order to confront with compulsions. But through psychopharmacological treatment, it is not possible.



Eventually, it is recommended that the superior treatment for OCD is CBT. And if it is supposed that the psychopharmacological treatment to be used, it is better to be accompanied by CBT and step by step we reduce the drug dose until the fear and worry of being dependent on the drugs to be eliminated.

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