Cognitive Behavioural Therapy for treatment in Obsessive Compulsive Disorder

Ruchika Joshi, Rajeev Pandey, Gurumurthy

ABSTRACT- Physical and mental well-being is important criterion to define overall health of a person. Modern era has seen an increased number of mental disorder cases. One of the common disorders includes Obsessive Compulsive Disorder [OCD], a mental disorder in which people have recurring, unwanted thoughts, ideas, or sensations (obsessions) that make them feel driven to do something repetitively (compulsions). In this article we focus on one of the treatment aspects of Obsessive-Compulsive Disorder that is Cognitive Behaviour Therapy [CBT], including Exposure and Response Prevention [ERP] as an effective treatment for the disorder.

Index Terms- Cognitive behaviour therapy, exposure and response prevention, genetic component, habituation phenomena, obsessive compulsive disorder, parental role, therapy along with medications, willingness, and motivation for treatment

1 Introduction

Obsessive Compulsive Disorder is a disorder where people feel the need to check things repeatedly, perform certain routines repeatedly, or have certain thoughts repeatedly.[1] Obsessive Compulsive Disorder often causes a high degree of distress and impaired functioning, with a fluctuating course and high risk of chronic outcomes. [2] Obsessive Compulsive Disorder affects about 2.3% of people at some point in their life. [3] Rates during a given year are about 1.2% and it occurs worldwide. [4] It is unusual for symptoms to begin after the age of thirty-five, and half of people develop problems before twenty. Males and females are affected about equally. [1][4] Obsessive Compulsive Disorder related impairment interferes with the child's daily functioning as in family, social and academic performance and may have an adverse impact on child's psychosocial development. [5]

- *Ruchika Joshi, a student of Spartan Health Sciences University will be starting clinical rotations at Weiss Memorial Hospital, Chicago. E-mail: ruchikajoshi3@gmail.com*
- *Rajeev Pandey is the Dean of Admissions and Course Director and Associate Professor of Department of Biochemistry at Spartan Health Sciences University, Saint Lucia*
- *Gurumurthy is the Dean of college and Associate professor of Neuroanatomy at Spartan Health Sciences University, Saint Lucia*

2 Signs And Symptoms

Obsessive Compulsive Disorder can present with a wide variety of symptoms. Certain groups of symptoms typically occur together. These groups are sometimes viewed as dimensions or clusters that may reflect an underlying process. The standard assessment tool for Obsessive Compulsive Disorder, the Yale-Brown Obsessive-Compulsive Scale [YBOCS], has 13 predefined categories of symptoms. These symptoms fit into three to five groupings. [6] A meta analytic review of symptom structures found a four-factor structure(grouping) to be most reliable. The observed groups included a symmetry factor, a forbidden thoughts factor, a cleaning factor, and a hoarding factor.

The symmetry factor -correlated highly with obsessions related to ordering, counting, symmetry as well as repeating compulsions.

The forbidden thoughts factor -correlated highly with intrusive and distressing thoughts of a violent, religious, or sexual nature.

The cleaning factor -correlated highly with obsessions about contamination and compulsions related to cleaning.

The hoarding factor - only involved hoarding related obsessions and compulsions and was identified as being distinct from other symptom groupings. [7]

3 Obsession And Compulsion

3.1 Obsessions

Obsessions are thoughts that recur and persist despite efforts to ignore or confront them. [8] Individuals with Obsessive Compulsive Disorder do not want to have these thoughts and find them disturbing. In most cases, people with Obsessive Compulsive Disorder realize that these thoughts do not make any sense. Obsessions are typically accompanied by intense and uncomfortable feelings such as fear, disgust, doubt, or a feeling that things must be done in a way that is "just right." In the context of Obsessive-Compulsive Disorder, obsessions are time consuming and get in the way of important activities the person values. Obsessive Compulsive Disorder sometimes manifests without overt compulsions, referred to as Primarily Obsessional Obsessive-Compulsive Disorder. Obsessive Compulsive Disorder without overt compulsions could, by one estimate, characterize as many as 50 percent to 60 percent of Obsessive-Compulsive Disorder cases. [9]

3.2 Compulsions

Compulsions are the second part of obsessive-compulsive disorder. These are repetitive behaviours or thoughts that a person uses with the intention of neutralizing, counteracting, or making their obsessions go away. People with Obsessive Compulsive Disorder realize this is only a temporary solution but without a better way to cope they rely on the compulsion as a temporary escape. Compulsions can also include avoiding situations that trigger obsessions. Compulsions are time consuming and get in the way of important activities the person values. Some individuals with Obsessive Compulsive Disorder are aware that their behaviours are not rational but feel compelled to follow through with them to fend off feelings of panic or dread. [10] Compulsions are different from tics (such as touching, tapping, rubbing or blinking) [11] and stereotyped movements (such as head banging, body rocking or self-biting), which usually aren't as complex and aren't precipitated by obsessions.

4 Causes

The cause is unknown. Both environmental and genetic factors are believed to play a role. Risk factors include a history of child abuse or other stress-inducing event. [4] It is thought that differences in the brain and genes of those affected may play a role.

4.1 Genetics

Obsessive Compulsive Disorder does run in families, and that genes likely play a role in the development of the disorder. Genes appear to be only partly responsible for causing the disorder, though. Genetic factors account for 45–65% of the variability in Obsessive Compulsive Disorder symptoms in children diagnosed with the disorder. [12]

PANDAS (Paediatric Autoimmune Neuropsychiatric Disorders Associated with Streptococcal infections) is a type of Obsessive-Compulsive Disorder that occurs in childhood following the body's reaction to infection. PANDAS look quite different from other forms of childhood Obsessive Compulsive Disorder, the most obvious difference being that it happens very suddenly, with the child starting to have symptoms seemingly overnight, and has a very severe impact on the child's life.

5 Treatment

A form of psychotherapy called "cognitive behavioural therapy" and psychotropic medications like selective serotonin reuptake inhibitors are first-line treatments for Obsessive Compulsive Disorder. Other forms of psychotherapy, such as psychodynamic and psychoanalysis may help in managing some aspects of the disorder. [13] Combination of Cognitive behavioural therapy and medication is also effective. Medication may reduce the anxiety enough for a person to start, and eventually succeed in therapy. Exposure and Response Prevention should also form part of the Cognitive behavioural therapy treatment. This involves being exposed in a very structured way, with the support of your therapist, to whatever it is that makes you feel anxious, without then engaging in the checking or other Obsessive-Compulsive Disorder

behaviours. [20] The habituation phenomenon, that is at each repetition of the exercises, the intensity of anxiety and the impulse to perform the rituals lowers, is the basis of Exposure and Response Prevention. [33],[34],[35],[36],[37] In case the exercises are repeated enough times, both the anxiety and the need to do the rituals disappeared completely. Similar or slightly higher efficacy of Exposure and Response Prevention therapy as compared to selective serotonin reuptake inhibitors was found in several clinical trials, [38],[39] and in several metanalyses, [40],[41],[42]having been definitively consolidated as the first choice treatment when rituals prevail and the symptoms have mild to moderate intensity. Recent studies have confirmed some advantages of CBT as compared to medications. [29],[30]

Relapses in patients who had complete remission of symptoms are rare, but they are common when the remission is partial, and in this situation, therapy must be restarted, even for a few sessions. Maintenance program for different periods after the end of treatment clearly reduces the rate of relapses.

6 Review Of Literature

6.1 Cognitive Behavioural Therapy For OCD

Nor Christian Torp et al, 2014 explains about the effectiveness of cognitive behaviour treatment. The exposure-based Cognitive Behavioural Therapy treatment manual was based on the study protocol designed by March and Mulle in collaboration with Foa and Kozak [14]. The manual was modified by adding more extensive family participation based on the work of Piacentini, Langley and Roblek [15]. Exposure-based Cognitive Behavioural Therapy regime consisted of 75 min weekly sessions for 14 weeks. A total of 767 children and adolescents were screened for participation, 491 met inclusion criteria for assessment, and 269 were chosen for the study. Parents were expected to accompany their children to all sessions. The children were seen together with their parents in six of the fourteen sessions. The focus of the treatment was a gradual exposure to threatening situations based on a detailed symptom hierarchy, with the goal to reach the top of the hierarchy. Homework exposure exercises were an essential part of the treatment, parents were asked to support and monitor homework assignments, at least for younger children. Towards the end of the therapy, the emphasis shifted to generalizing skills and relapse prevention.

6.2 Measures

The following instruments were used as measures for inclusion, and measures of treatment outcome:

Schedule for Affective Disorders and Schizophrenia for School Age Children Present and Lifetime version (K-SADS-PL) [16]

Children Yale-Brown Obsessive-Compulsive Scale (CY-BOCS). [17]

And the outcome included the CY-BOCS total and mean score followed by its interpretation [21]

Selles R.R et.al, 2017 suggests group family based cognitive based therapy for Obsessive Compulsive Disorder patients. Eighty-five OCD-affected youth aged 8-18 years and their parent(s) participated in a weekly, 12-session Group Family-CBT program. Data from multiple perspectives were gathered at the beginning and end of treatment, as well as at one-month follow-up. A broad range of assessment measures were utilized to capture clinically relevant domains and several potential predictor variables were explored and the behaviour was analysed. [18]. Efficacy of group Cognitive Behavioural Therapy in the treatment of Obsessive-Compulsive symptoms [24],[25],[26]is like that of individual Exposure and Response Prevention. [27],[28]

Reid AM et.al,2017 focuses on the personal aspect of the patient that is how willing a patient is to receive the treatment and follow it. Exposure and response prevention are an effective treatment for individuals with obsessive-compulsive disorder, yet a substantial number of individuals with Obsessive Compulsive Disorder do not fully respond to this intervention. Two hundred eighty-eight adults with Obsessive Compulsive Disorder receiving residential Exposure and Response Prevention provided self-rated willingness and other exposure-related

variables during each daily coached Exposure and Response Prevention session. Obsessive-compulsive and depressive symptom severity was assessed every week. Multilevel modelling was used to study the impact of willingness on treatment outcome during the first 6 weeks of residential care. It was understood that individuals with higher willingness during Exposure and Response Prevention reported faster symptom reduction during residential treatment, even when controlling for length of stay, psychopharmacological intervention, depression, adherence, and rituals performed during Exposure and Response Prevention. These results appear to have both statistical and clinical significance. [19]

7 Conclusion

Paediatric patients treated with exposure-based Cognitive behavioural therapy, showed a high treatment response. The severity of OCD symptoms decreased significantly over the course of treatment. Cognitive behavioural therapy proves to be a remarkably effective treatment with positive results in reducing the symptoms and helping the patient to live normally.

Group family-CBT significantly improves a wide range of domains for youth/families that extends beyond OCD symptom severity and supports homework as a core treatment component. This suggests that family involvement and support acts as a significant factor for better treatment course and faster improvement. Apart from sessions with therapist, the homework which is to be done by patients on their own also helps in accelerating the treatment process.

Willingness to fully experience unpleasant and unwanted thoughts, emotions, and bodily sensations during exposures appears to be a marker of successful exposure therapy in adults with OCD as this suggests that the patient wishes to face the obstacles and resolve them for better future living. Accepting the problems within oneself and working towards its betterment is the deal breaker and the course of treatment follows which helps in resolving the symptoms

Motivation is an important aspect in the successful treatment of paediatric obsessive-compulsive disorder as it requires extensive client involvement like participating in exposures and doing homework tasks. Lack of motivation hinders the treatment procedure and the outcome of the result.

Cognitive behavioural therapy along with medications like selective serotonin reuptake inhibitors is also immensely helpful in treating the patients but their individual use is same as combined effect. The other effects of combined therapy are still under question awaiting to be answered.

REFERENCES

[1] The National Institute of Mental Health (NIMH) (January 2016). "What is Obsessive-Compulsive Disorder (OCD)?". U.S. National Institutes of Health (NIH). Archived from the original on 23 July 2016. Retrieved 24 July 2016. (Journal citation)

[2] Piacentini.J, bergman.R, Keller.M and Mccracken.J [2003]. Functional impairement in children and adolescents with obsessive compulsive disorder. Journal of child and adolescent pyscopharmacology. (Journal citation)

[3] Goodman, WK; Grice, DE; Lapidus, KA; Coffey, BJ (September 2014). "Obsessive-compulsive disorder". The Psychiatric clinics of North America. (Journal citation)

[4] Diagnostic and statistical manual of mental disorders : DSM-5 (5 ed.). Washington: American Psychiatric Publishing. 2013. pp. 237–242 (Journal citation)

[5] Peris.T.s, Bergman.R, Langley.A, Chang.S, Mccracken.J.T and Piacentini.J [2008]. Correlates of accommodation of pediatric obsessive compulsive disorder: parent, child and family characteristics. Journal of the American academy of child and adolescent psychiatry, 47(10), 1173-1181 (Journal citation)

[6] Leckman, JF; Bloch, MH; King, RA (2009). "Symptom dimensions and subtypes of obsessive-compulsive disorder: a developmental perspective". Dialogues in clinical neuroscience. 11 (1): 21–33 (Journal citation)

[7] Bloch, MH; Landeros-Weisenberger, A; Rosario, MC; Pittenger, C; Leckman, JF (December 2008). "Meta-analysis of the symptom structure of obsessive-compulsive disorder". The American Journal of Psychiatry. 165 (12): 1532–42. (Journal citation)

[8] Markarian Y, Larson MJ, Aldea MA, Baldwin SA, Good D, Berkeljon A, Murphy TK, Storch EA, McKay D (February 2010). "Multiple pathways to functional impairment in obsessive-compulsive disorder". Clin Psychol Rev. 30 (1): 78–88 (Journal citation)

[9] Weisman M.M.; Bland R.C.; Canino G.J.; Greenwald S.; Hwu H.G.; Lee C.K.; et al. (1994). "The cross national epidemiology of obsessive–compulsive disorder". Journal of Clinical Psychiatry. 55: 5–10. (Journal citation)

[10] American Psychiatric Association, 2013, p. 7, archived (PDF) from the original on 19 October 2013, retrieved 12 April 2016 (Association)

[11] Conelea; et al. (2014), "Tic-related obsessive-compulsive disorder (OCD): phenomenology and treatment outcome in the Pediatric OCD Treatment Study II", Journal of the American Academy of Child & Adolescent Psychiatry, 53 (12): 1308–16 (Journal citation)

[12] Abramowitz JS, Taylor S, McKay D (2009). "Obsessive-compulsive disorder". Lancet. 374(9688): 491–9. (Journal citation)

[13] National Institute for Health and Clinical Excellence (NICE) (November 2005). "Obsessive-compulsive disorder: Core interventions in the treatment of obsessive-compulsive disorder and body dysmorphic disorder". Information about NICE Clinical Guideline 31. UK National Health Service (NHS). Archived from the original on 12 January 2017. Retrieved 24 July 2016. (journal)

[14] March, J. S., Mulle, K., Foa, E., & Kozak, M. J. (2000). Treatment of pediatric obsessivecompulsive disorder cognitive behavior therapy treatment manual. (Journal citation)

[15] Piacentini, J., Langley, A., & Roblek, T. (2007). Cognitive behavioral treatment of childhood OCD: It's only a false alarm : Therapist guide. New York, NY: Oxford University Press (press)

[16] Kaufman, J., Birmaher, B., Brent, D., & Rao, U. (1997). Schedule for Affective Disorders and Schizophrenia for School-Age Children-Present and Lifetime Version (K-SADS-PL): initial reliability and validity data. Journal of the American Academy of Child and Adolescent Psychiatry, 36(7), 980e988. (Journal citation)

[17] Scahill, L., Riddle, M. A., McSwiggin-Hardin, M., & Ort, S. I. (1997). Children's YaleBrown Obsessive Compulsive Scale: reliability and validity. Journal of the American Academy of Child and Adolescent Psychiatry, 36(6), 844e852 (Journal citation)

[18] Psychiatry Res. 2017 Nov 15;260:116-122. doi: 10.1016/j.psychres.2017. [Journal citation]

[19] Depress Anxiety. 2017 Nov;34(11):1057-1064. doi: 10.1002/da.22672. Epub 2017 Jul 17. [Journal citation]

[20] https://www.ocduk.org/ocd-treatments [url link, 2018]

[21] https://ac.els-cdn.com [url link, 2016]

[22] J Clin Psychol. 2016 Nov;72(11):1139-1151. doi: 10.1002/jclp.22394. Epub 2016 Sep 22 [Journal citation]

[23] http://www.veale.co.uk/wp-content/uploads/2010/10/56-CBT-for-OCD-2007.pdf (Journal citation)

[24] Whittal ML, Thordarson DS, McLean PD. Treatment of obsessive-compulsive disorder: cognitive behavior therapy vs. exposure and response prevention. Behav Res Ther. 2005;43(12):1559-76. [Journal citation]

[25] Volpato Cordioli A, Heldt E, Braga Bochi D, Margis R, Basso de Sousa M, Fonseca Tonello J, Gus Manfro G, Kapczinski F. Cognitive-behavioral group therapy in obsessive-compulsive disorder: a randomized clinical trial. Psychother Psychosom. 2003;72(4):211-6. [Publication]

[26] Cordioli AV, Heldt E, Bochi DB, Margis R, Sousa MB, Tonello JF, Teruchkin B, Kapczinski F. Time-limited cognitive-behavioral group therapy in the treatment of obsessive-compulsive disorder: an open clinical trial. Rev Bras Psiquiatr. 2002;24:113-20. [Publication]

[27] Fals-Stewart W, Marks AP, Schafer J. A comparison of behavioral group therapy and individual behavior therapy in treating obsessive-compulsive disorder. J Nerv Ment Dis. 1993;181(3):189-93. [Publication]

[28] Anderson RA, Rees CS. Group versus individual cognitive-behavioural treatment for obsessive-compulsive disorder: a controlled trial. Behav Res Ther. 2007;45(1):123-37. [Publication]

[29] Foa EB, Liebowitz MR, Kozak MJ, Davies S, Campeas R, Franklin ME, Huppert JD, Kjernisted K, Rowan V, Schmidt AB, Simpson HB, Tu X. Randomized, placebo-controlled trial of exposure and ritual prevention, clomipramine, and their combination in the treatment of obsessive-compulsive disorder. Am J Psychiatry. 2005;162(1):151-61. [Publication]

[30] Sousa MB, Isolan LR, Oliveira RR, Manfro GG, Cordioli AV. A randomized clinical trial of cognitive-behavioral group therapy and sertraline in the treatment of obsessive-compulsive disorder. J Clin Psychiatry. 2006;67(7):1133-9. [Publication]

[31] Hiss H, Foa EB, Kozak MJ. Relapse prevention program for treatment of obsessive-compulsive disorder. J Consult Clin Psychol. 1994;62(4):801-8. [Publication]

[32] McKay D, Todaro J, Neziroglu F, Yaryura-Tobias JA. Evaluation of a naturalistic maintenance program in the treatment of obsessive-compulsive disorder: a preliminary investigation. J Anxiety Disord. 1996;10:211-7. [Publication]