

## Distressed Lonely Siblings' Struggle with Obsessive Compulsive Disorder

Dharmender Nehra<sup>1</sup>, Jagdish Chander Bathla<sup>2</sup>, Pradeep Kumar<sup>3</sup>

<sup>1</sup>Clinical Psychologist, State Institute of Mental Health, UHS, Haryana, India

<sup>2</sup>Psychiatrist, Bathla Psychiatric Hospital, Karnal, Haryana, India

<sup>3</sup>Psychiatric Social Worker, State Institute of Mental Health, UHS, Rohtak, Haryana, India

### ABSTRACT


**Background:** Obsessive Compulsive Disorder (OCD) is a common and often disabling, psychiatric disorder. Earlier it was considered a difficult-to-treat disorder these viewpoints are radically changed in the last three decades as cognitive behavioural therapy (exposure and response prevention therapy), has shown significant results for individuals suffering from OCD. In the present report, two cases of Obsessive Compulsive Disorder (OCD), which happened to be siblings (one male one female), are being reported. In contrast to most other case reports depicted in world literature, the two siblings reported here were living under a roof but couldn't talk for years. Both felt that their relationship suffered badly through their illness; as both of them were having a distressing sexual obsession of each other, along with other compulsions. The case report illustrated the journey of two distressed and lonely siblings' struggle with OCD. **Assessment & Management:** OCD was diagnosed applying the existing criteria for OCD in the tenth revision of the International Statistical Classification of Disease and Related Health Problems (ICD-10), in addition, Y-BOCS also used to determine the severity of symptoms, pre-treatment and improvement Post-treatment. Therapy was adapted component from cognitive behaviour therapy (CBT) & exposure and response prevention (ERP) and typically involves 16 to 20 sessions. **Outcome:** This case report shows that Psychological intervention led to significant symptomatic improvement in the patients discussed. By present findings and understanding of the cases, it is to claim for sure that for successful treatment of OCD psychological treatment must be used.

**Keywords:** Obsessive compulsive disorder, sexual thoughts, exposure and response prevention

### INTRODUCTION

Obsessive Compulsive Disorder (OCD) is a common and often disabling, psychiatric disorder<sup>[1]</sup> that can manifest with a wide range of clinical pictures.<sup>[2]</sup> It is characterized by the presence of either obsession (recurrent, intrusive, unwanted, repugnant thoughts) or compulsion (repetitive, stereotypic, purposeful behaviour), but commonly both. It has been shown that most people with OCD experience both obsessions and compulsions and that is up to 90% of the cases, the compulsions are seen as functionally related to obsessions.<sup>[3]</sup> Both adult- and childhood-onset OCD were once thought to be a rare condition affecting

less than 1 in 1,000 individuals; however, advances in diagnosis and treatment have led to increased identification of the disorder.<sup>[4]</sup> The latent symptom structure of OCD can be best defined by four specific dimensions: (a) obsessions and checking (e.g., aggressive, sexual, religious, and somatic obsessions and checking compulsions); (b) symmetry and ordering (e.g., symmetry and exactness obsessions, repeating, counting, and arranging compulsions); (c) contamination and cleaning (e.g., contamination obsessions and cleaning/washing compulsions); and (d) hoarding.<sup>[5]</sup> There is some evidence of gender differences in symptom expression, with women displaying more washing and cleaning

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#### Address for Correspondence:

Dr. Pradeep Kumar, Psychiatric Social Worker, State Institute of Mental Health, UHS, Rohtak, Haryana - 124001, India Email: [pradeep.meghu@gmail.com](mailto:pradeep.meghu@gmail.com)

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rituals and men reporting more sexual & religious obsessions.<sup>[6-9]</sup> Untreated OCD usually runs a chronic, lifelong course, fluctuating in intensity but rarely disappearing.<sup>[10]</sup> Sexual obsessions may comprise ego-dystonic, intrusive, recurrent and persistent thoughts, images or concerns about sexual matters that do not usually prompt sexual behaviour.<sup>[11]</sup> Sexual obsessions are reported to be ranged from 6% to 24%<sup>[12,13]</sup> among subjects with OCD; sexual obsessions area that has seen little research.<sup>[14]</sup> Veale et al.<sup>[15]</sup> in his article 'Risk assessment and management in OCD' did a fabulous review of various factors differentiating the intrusive sexual thoughts of people with OCD from those of sexual offenders, these are as follow: Ego-dystonic (contrary to their view of themselves) thoughts; failure to act on or masturbate to the thoughts; Avoidance of trigger situations; Efforts to suppress the thoughts; very frequent or constant occurrence of the thoughts; dominant anxiety, distress and guilt about the thoughts; over-disclosure of irrelevant past sexual history; wanting help and seeking referral to mental health services; Presence of additional obsessive-compulsive symptoms.<sup>[15]</sup> In terms of psychotherapeutic interventions for OCD, research suggests that, compared to most other forms of OCD (i.e., contamination or checking), sexual obsessions take longer to treat.<sup>[16]</sup>

Earlier it was considered a difficult-to-treat disorder<sup>[17]</sup> these viewpoints are radically changed in the last three decades as cognitive behavioural therapy and exposure and response prevention therapy, has shown significant results for individuals suffering from OCD.<sup>[18,19]</sup> Behavioural therapy utilizing exposure and response prevention (ERP) is considered the psychosocial treatment of choice for obsessive-compulsive disorder.<sup>[20]</sup> ERP procedure that includes both (a) daily sessions of deliberate exposure to anxiety-provoking situations lasting until significant habituation occurs, and (b) strict abstinence from performing rituals.<sup>[21, 22]</sup> One controlled study found cognitive therapy's effectiveness is similar to that of exposure and response prevention in treating OCD.<sup>[23]</sup> Even a recent meta-analysis found that CBT gives better results than exclusive pharmacotherapy.<sup>[24]</sup> Psychotherapy (CBT) for OCD has been divided into two forms: (a) CBT that relies

primarily on behavioural techniques, such as ERP, and (b) CBT that relies primarily on cognitive therapy techniques, such as identifying, challenging, and modifying faulty beliefs. In clinical practice, these two forms are often combined.<sup>[25]</sup> Combination Therapy is commonly used and recommended in the treatment of OCD.<sup>[26]</sup> OCD is generally believed to be difficult to treat the disorder,<sup>[17]</sup> but both of the treated patients in this report improved. Between the baseline and post treatment assessments, OCD symptom severity significantly decreased and the level of functioning significantly improved. In world literature, the proportion of clinical responder defined as those patients who showed at least 30% improvement with treatment, 33% for response prevention, 55% for exposure and 90% for combined treatment.<sup>[23,27]</sup> Present case report will provide an insight towards the fact that OCD can be successfully treated with psychotherapy.

## BRIEF CLINICAL HISTORY

**Case 1:** A 27 years old male was brought to the Out-patient Department of Bathla Psychiatric Hospital, Karnal, Haryana, India by his father because of repeated hand washing and repeated checking and staying out of home excessively that was affecting his personal life. He admitted spending hours in repeated washing and checking behaviours. Furthermore, he reported several repeated compulsive behaviours, including hand washing, wallet checking, mobile checking, checking whether he dialled someone's contact number (by mistake or unintentionally), checking whether he had hurt/killed some while driving/riding, accidentally. At the time of intake, he was participating minimally in daily activities.

He reported that he was asymptomatic about 11 years back when he was preparing for board exams. He used to be a bright student and his parents were planning to send him Kota for Pre Medical Test coaching after board exam. But in spite of his good preparation one month before the exams he started having doubts about his ability to pass the exam; followed by excessive hand washing with the fear that touching books with dirty hand makes the Goddess of knowledge (Mata Sarasvati) angry that could lead failure in the exam. At the same time, he also started

wasting a lot of time in playing video games with the thought that if he scores up to the decided points in the game then he would be able to score well in the exam otherwise he got failed. The result of these time-consuming activities leads him to score poorly in the final exam and he had to drop the idea of getting admission in medical education; hence, he got himself admitted in Bachelor degree in Science (B.Sc) in a city away from his home and had to stay in the college hostel. In the hostel, he had to share the room with one of his classmate who as per him was very shabby and staying with that so-called shabby roommate make him to indulged in more hand washing. Gradually he also developed the symptoms of wallet checking, mobile checking and checking whether he dialled someone's contact number (bymistake/unintentionally), checking whether he had hurt/killed some while driving/riding accidentally. The deterioration of his symptoms lead to failure in the B.sc 1<sup>st</sup> year exam and his parents called him back home with the intention that he would do Bachelor of Arts via correspondence. While staying at home with his younger sister, who was staying along with him the whole day (as their parents were working); he started having unwanted sexual thoughts about her. The patient told that he did not use to have any sexual inclination towards her but used to be very possessive about her before coming back from College Hostel. Earlier he used to spend a lot of time along with her but after started having repeated sexual images of her (he said "I see myself having sex with my sister"), most of the time he would remain isolated as having guilt associated with his images. He would think that this is very bad on his part that he had such thoughts/images about his sister; which is not acceptable to him and due to these thought/images, sometimes he would get frustrated very badly and thought about becoming a baba (Monk). Pre-morbidly he has been an anxious and introvert type person. He had high moralistic value and would pay a lot of regard to his elders. By and large, he would have a satisfactory relationship with family members, peer groups, friends and relatives. He has been conscientious, the responsible person for his social duties. He has been fond of good food and dresses and most of the time would keep him presentable. The significant findings on MSE were sad mood, obsessive

thoughts, and feelings of guilt and Insight was found to be present.

**Case 2:** A 25 year old female (who happen to be real sister of Case 1), educated up to 12<sup>th</sup> standard, unemployed, unmarried, belonging to middle socio-economic strata, nuclear, rural, Hindu family, was presented with chief complaints of repetitive sexual thoughts, disturbed socio-occupational functioning for last 8 years with insidious onset, progressive course, having significant findings on MSE as helplessness, obsessive thoughts in thought content with no history suggestive of any organic involvement. The patient was apparently well about 8 years back; when she had passed her matriculation and was into her intermediate class. Since childhood, she had the habit of thinking about every little event that happened with her, but now since the past 8 years, this habit was getting beyond her own control, in the sense that she would keep thinking about trivial things. She reported that a few years back she saw her brother masturbating and after a day or two she has to wash the bed-sheet her brother was masturbating on; thinking about this was causing her much problem, and she started washing her hands again and again; being inboard class, as her academic pressure have increased, she found it very difficult to cope. Gradually she started having an unwanted sexual thought about her own brother, gas checking, checking on bed whether she gave birth to any child. Most of the ruminating thoughts would be regarding what she should do in a situation when she would have to touch her brother on some occasions like Rakhi festival; that as per her having sexual thoughts are wrong morally. Since she was attributed these thoughts unjustified and she keeps regretting what she thinks and has thoughts of what should have been done in that situation. She, however, never reaches to any conclusion about it. Another frequent thought that keeps coming to her is about an act that she had committed (touch the bedsheet on which her brother was masturbating). This incident had occurred about 8 years ago, and she keeps on having disturbing thoughts related to the incident and she keeps on questioning and explaining to herself to what she should have, must have done in that situation. However, here too, no ultimate solution is reached, and the thoughts keep coming to her mind. Since

then she told that she started having repetitive sexual thoughts about his brother (“*I experience sexual thoughts about my own brother*”). Gradually she also started having repetitive thoughts about shapes and structures of different body parts including genital of her brother. Gradually the intensity and frequency of these thoughts increased in such a way that she always used to preoccupy along with these thoughts only and always used to ruminate about them. After some time these thoughts became so disturbing for her that she started remaining very tense and upset and started avoiding her brother. She told that since the onset of illness her social functioning also had been disturbed significantly. Her socialization was decreased and did not want to participate in a social gathering in the colony, festivals and any function or parties. Generally, she would avoid males to see and meet and did not initiate to interact. She also reported that she could not concentrate on her studies and would forget the things easily. Due to this, her study would suffer a lot and she discontinued her study after a poor performance in 12<sup>th</sup> standards and she felt that she could not do anything confidently.

Presently, the thoughts have become so frequent and intense that she has these thoughts for most of the time. The more the thoughts come; the more she tries to avoid them. This she does deliberately by forcefully diverting her attention to something else. To clarify she reported example that she start reading aloud from the book, or she tried to think about some other thing, forcing her attention towards it. But according to here, these efforts only help for a very short while, and thoughts come back with even greater intensity, making her feels very distressed.

## ASSESSMENTS

After having a thorough examination of symptoms by taking the psychiatric history, diagnosed was made as per ICD-10 criteria. After establishing the diagnosis and severity of OCD, both the cases were considered for treatment including psychotherapy. Taking into consideration the nature of illness, and mode of intervention plan, assessments of different aspects of the problem were also done by using Likert Scale and diary method, which included assessing Cognitive Aspect (form of obsession; content of obsession;

whether thoughts are upsetting; whether thoughts come uninvited; subjective triggers; cognitive neutralizing; cognitive avoidance); Emotional Aspect (nature of mood changes associated with obsession; whether mood changes precede or follow the obsessions); Behavioural aspect (trigger; prevent exposure to them (avoidance); terminate exposure to them; prevent reappraisal) were examined in detail. In addition, following points were also assessed, behaviour problems patients were having (decreased socialization; don't interact with males/females; loss of interest in pleasurable activities; obsessive rumination; work impairment); Cognitive problems (I can't do anything; There is nothing to be happy; I should not interact to females to avoid the distressing thoughts; Life has been worst). After completing the baseline assessments it was decided to assess the patient on different parameters with the help of some objective assessment tools. YBOCS<sup>[28]</sup> was also administered with the patients to measure obsessions and compulsions. On this 10-items scale (items 1 to 5 for **obsessions** and items 6 to 10 for compulsions), both cases pre-treatment scored 26 and 30 respectively, “which is higher than the cut-off (16) cited by other researchers.<sup>[29]</sup> When administering the Y-BOCS, the interviewer rates the following parameters time, interference with functioning, distress, resistance, and control. Items are rated on a scale ranging from 0 (no symptoms) to 4 (extreme). The total score is the sum of the 10 items and therefore ranges from 0 to 40. Y-BOCS scores of 0 to 7 indicate subclinical OCD, 8 to 15 indicate mild symptoms, 16 to 25 indicate moderate symptoms, 26 to 35 indicate severe symptoms, and 36 to 40 indicate extreme severity as earlier used in world literature.<sup>[29]</sup> After the assessment, both of them were explained regarding the nature of the problem and need for treatment compliance along with treatment available. Both the cases were also decided to go for non-pharmacological intervention. After taking their consent, treatment started with both of them.

## COURSE OF TREATMENT AND PROGRESS OF ASSESSMENT

After building rapport with the patient, during the history taking and assessment session, the focus was shifted to the interventions. These current cases were planned to be managed

with the help of psychotherapy; they were taken up for Cognitive Behaviour Therapy-Exposer and Response Prevention (ERP), promising approaches for OCD. The standard program used with these cases was distributed across 16-20 weekly sessions. Each session would include a statement of goals for that session, review of the preceding week, the introduction of new information, and homework for the coming week, and monitoring procedure. The first few sessions of the therapy were devoted to **psycho-educate** the patient. The nature of the illness was explained to the patients, the common etiological factors and the factors which maintain the illness were also explained. The issue of prognosis of the disorder, the treatment involved and the issue of compliance was also discussed, where it was highlighted that the discontinuation of the treatment may lead to the worst picture. Psycho-education began with a description of the nature of OCD (with an emphasis on the fact that OCD is a disorder; not a reflection of weakness or character) and rationale behind ERP (neutralization maintains problem and habituation are needed) was explained by showing anxiety graphs (by explaining their symptoms). The next part of the educational component was to explain the nature of behavioural activities, both mental (feeling sorry; refuting self; self-blaming) and overt (avoidance, escape behaviour; reassurance seeking, checking etc.), and how these neutralization acts have maintaining role in their problem, to make information easily understandable, metaphors, analogy and storytelling were used, for example "unwanted guest" ("An unwanted thought is like an unwanted guest, pay no attention to the guest, don't feed the guest, don't talk to the guest, and rest assured, the guest will leave eventually-Anonymous").<sup>[30]</sup> They were explained by telling that "If an unwanted guest (e.g. bagger) with bad intentions comes to your home and whenever he visits you provide him all the things he wish to get (it is different thing that you don't want/like to give him the things); then what is the probability that he would stop coming to your place. Yes, the probability is high that he would never stop visiting you even his visits would be more frequent gradually provided you fulfil his wishes. If you really do not want to see him any more than you have to follow at least two above

mentioned rules (1) do not give him the things he intend to get whenever he visits you himself (2) if possible call him intensely and whenever he comes don't give him the things you used to give him or he intended to get. For example, suppose the guest comes to you to take tea/money etc. then whenever he comes don't offer him tea/money (if this rule is followed; then definitely the frequency of his visit would be decreased because he comes with an intention that is not fulfilled). In addition, when-ever you notice that frequency of his visits are decreased then try to call him in intensely and whenever he comes to you again don't offer him the things you know he intend to get or you used to give him; this rule would further decrease the probability of his coming even you intensely call him". The idea postulated by Freeston & Ladouceur<sup>[31]</sup> "the more that we try not to think about something, the more the thought comes to mind" was explained via a short experiment called camel effect<sup>[31]</sup>, that was conducted in two phases: In first phases of the experiment patients were instructed to close their eyes while trying to think about a camel for two minutes. Each time that the camel disappears from their minds, they were instructed to indicate it by lifting their fingers. During the second phases, they were further instructed to close their eyes while trying not to think about a camel for two minutes and to lift their finger each time that the thought appears. The therapist kept the records of many times fingers were raised in both the phases of the experiment by the patients individually. Just after providing them psycho-education, goal of the CBT was set and patients were explained that the goal of the therapy is not to eliminate the thoughts but to change one's reactions to the thoughts by changing the importance that is being attached to the thoughts, to change the strategies that are used that eventually lead to decreased frequency and the duration of the thoughts along with the associated discomfort.<sup>[31]</sup> A formulation of the problem for an understanding of how it developed and how it is being maintained was developed with the help of each patient. Self-monitoring was introduced in the first session, just after target symptoms were identified. Two methods of self-monitoring were used: (1.) Daily Record, in which patients recorded the intrusive thoughts on an hourly basis. (2) Diary form, in which the patients analyzed the experience in

an A-B-C sequence (a) activating events (the situations and trigger-e.g. seeing someone walking on road.) (b) Beliefs (e.g. I hurt him/her by accident?) (c) Consequences (emotional and behavioural reaction-feeling anxious and looking back in rear mirror of vehicle).

The **next few sessions** were focused to Construction of exposure hierarchy with assistance from the therapist, both the patients constructed an exposure hierarchy that had to be used and implement the therapeutic techniques including exposure and ritual prevention. Both the patients were assured that they would not be pressurized to do any of these exposure exercises without their wish and readiness. The methods which were targeted for immediate intervention was the Self-Monitoring of compulsion acts and obsessive thoughts in terms of associated distress; frequency of thoughts; time consumed in compulsive act/thoughts. The patient was also given a homework assignment to practice the above mentioned therapeutic techniques and to rate all the activities on 10 points Likert Scales in terms of pleasure and mastery. Following by developing a hierarchy of intrusive thoughts and, based on this hierarchy, loop tapes of their personalized obsessive thoughts were created. With therapist guidance, patients were able to listen to these tapes in session without performing associated cognitive rituals. They were next asked to repeat these exposures at home, in the presence of sibling, until they no longer evoked anxiety, off course based on hierarchy. During the exposure and response prevention (ERP), the patients were persuaded to expose themselves to the anxiety provoking stimuli (i.e. unwanted sexual thoughts/images etc.) and prevented from doing rituals (i.e. avoiding seeing a sibling or criticizing oneself, etc.). The rationale provided to patients was that by experiencing exposure without rituals, they would learn that anxiety decreases with time alone (“habituation”) and that feared consequences do not occur. To assess the assumptions held, inductive reasoning/ downward arrow techniques and diary were used. Furthermore, cognitive therapy techniques were used to deal with misinterpretations about the significance of these intrusions (e.g., “Having these thoughts (sexual) means I’m a bad person”, “I should

always have control over my thoughts”) thoughts. These assumptions were then used in cognitive restructuring and explaining thought-action fusion and unwanted guest example; to restructure patients’ belief system. In addition to helping the patients distance them from the belief Prospective hypothesis testing (testing a belief prospectively) were used i.e. having a thoughts does not guarantee a fact or thoughts are necessarily not facts. For example, thinking of being a prime minister does not automatically make one prime minister. The patients were asked to carry out homework assignment in which he/she had to rate discomfort produced by particular thought and urge to neutralize thoughts at a different time in a day whenever he/she had any obsessive thoughts and asked to maintain a separate diary for the same. The patients were also asked to practice the above mentioned Cognitive Correction techniques regularly between sessions as homework assignments.

## OUTCOME

The final session focused on re-administered of YBOCS, in both cases initial pre-treatment scores were 26 and 30 respectively, on the YBOCS that were reduced significantly at post-treatment with that of 5 and 7 (respectively); which are below the cut-off point and indicating clinically significant improvement.

**Follow-Up:** It is important to note that even after years patient reported occasional thoughts of the same content but having no subjective distress associated with these thoughts or images (patients started taking treatment in Month of June 2011 and in March 2018 they were again contacted over the phone).

## DISCUSSION

As per Obsessive-Compulsive Cognitions Working Group,<sup>[32]</sup> following beliefs domains could contribute to the origins and maintenance of OCD symptoms: (1) inflated responsibility, (2) over-importance of thoughts, (3) excessive concern about the importance of controlling one's thoughts, (4) overestimation of threat, (5) intolerance of uncertainty and (6) perfectionism.<sup>[32]</sup> Experts<sup>[33]</sup> stresses that special attention should be given to covert rituals during treatment as people with sexual obsessions are less likely to

have overt rituals, and more likely to engage in mental compulsions and repeated reassurance-seeking.<sup>[34,35]</sup> Veale<sup>[36]</sup> reported some cognitive biases that are found in patients with OCD that are: Overestimation of the likelihood that harm will occur; Belief in being more vulnerable to danger; Intolerance of uncertainty, ambiguity and change; need for control; Excessively narrow focusing of attention to monitor for potential threats; Excessive attention bias on monitoring intrusive thoughts, images or urges; Reduced attention to real events.<sup>[36]</sup> According to the cognitive theory of OCD,<sup>[37,38]</sup> obsession problems may arise when individuals experience an inflated sense of responsibility for their own thoughts. Thought-action fusion is a cognitive distortion which describes beliefs about the equivalence of thoughts and actions. Two different types of Thought-action fusion (TAF) have been identified: (a) moral TAF is the belief that having unacceptable thoughts, images, or impulses are as bad as actually carrying them out and (b) likelihood TAF is the belief that having an unacceptable or disturbing thought will increase the likelihood that the thought will occur in reality.<sup>[39]</sup> This case study illustrates the complexities of compulsions and sexual thoughts in OCD, which were carefully considered while creating and choosing the integral model of treatment. This model could be further examined in a larger number of patients with OCD, and the prospective study designs should enable a more thorough assessment of the proposed model for the treatment of OCD.

In a nutshell, it can be recommended that psychological intervention is effective in the management of OCD symptoms. The significant improvement in present cases can be attributed to the content of the therapeutic program applied (a combination of CBT and ERP) that started by establishment of ERP model via explaining graph or providing unwanted guest example; followed by establishing the therapeutic contract with clear cut contract that patient needs to leave his avoidance behaviour via exposure of thoughts/images/situation while not engaging in neutralization acts. In addition, reassurance seeking was ceased by intentional withhold Reassurance whenever patients ask whether having sexual thoughts means I am immoral. Socratic Questioning used to promote new

positive cognitive change via exploration of the problem, identification of underlying assumptions, thoughts and images, their careful evaluation, and assessment of the consequences of these cognitions and behaviour. A meta-analysis found highest effect sizes for combined treatment.<sup>[40]</sup> Experts claimed that some people cannot tolerate the ERP component because of anxiety, consequently it is important to investigate whether the combination can increase efficacy and overcome some of the limitations of each treatment.<sup>[41]</sup> Whittal, Thordarson, McLean<sup>[42]</sup> compared exposure and response prevention (ERP) and cognitive behaviour therapy (CBT) delivered in an individual format and concluded that a higher percentage of CBT participants obtained recovered status at post-treatment and follow-up, compared to ERP participants, but the difference was not significant. Based on present findings, it can be postulated that a combination of Cognitive techniques with ERP is a very useful intervention for OCD.

## CONCLUSION

As a concluding aside, this case study arose as a result of two individuals who happened to be siblings (one male one female) and suffering from Obsessive Compulsive Disorder (OCD). The reasons for referring the cases were repetitive hand washing, checking behaviour, unwanted sexual images/thoughts about sibling etc. After psychological assessment and treatment, it was seen that psychological intervention mainly cognitive behaviour therapy and exposure & response prevention lead to significant symptomatic improvement in the aforesaid persons with the obsessive compulsive disorder. Finally, we wish to share our impression that combining CBT techniques may have abetted the application of the ERP procedure in the treatment of cases. Combining CBT techniques in ERP seems to be helped the cases to probe and challenge their thoughts in depth while they are having exposure while preventing rituals.

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