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EFFICACY OF COGNITIVE BEHAVIOR THERAPY FOR BETTER MANAGEMENT OF OCD

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ABSTRACT

This study claims that the primary goals of cognitive therapy are to solve problematic thinking patterns such overconfidence in dangers or too much responsibility. This research argues that integrating behavioral and cognitive aspects of cognitive-behavioral therapy (CBT) is both affordable and effective. Until the mid-1960s, obsessive-compulsive disorder (OCD) was thought to be treatment-resistant as both psychodynamic psychotherapy and medication had failed in appreciably lowering OCD symptoms. Exposure and ritual prevention brought forth in 1966 marked the first actual breakthrough. The cognitive behavioral conceptualizations that shaped the evolution of cognitive behavioral therapy for OCD will be discussed in this study. The use of early behavioral therapy and psychodynamic psychotherapy will be briefly discussed; none of these approaches had effective results with OCD. With a focus on versions of exposure and ritual or response prevention (EX/RP) therapies, the therapy that has demonstrated the greatest empirical evidence of its effectiveness, the study will mostly address contemporary cognitive behavioral therapy (CBT).

Keywords: *CBT, OCD*

1. INTRODUCTION

Obsessive Compulsive Disorder marks antiquity. In ancient literature, Shakespeare immortalized obsessive thoughts and repetitive hand washing rituals in the guilt-ridden character of Lady Macbeth in his play. Historically, people were considered to be possessed by an evil force who had obsessive sexual and blasphemous thoughts. This view

was consistent with beliefs of that time, and the treatment was to eliminate the evil force from the possessed soul. Exorcism or the spiritual and religious practice of evicting the demons was the choice of treatment for such conditions in the then time and it wasn't that effective.

Gradually, obsessive and compulsive symptoms (OC symptoms) have undergone a metamorphosis from a religious view to a medical view. Esquirol (1838) for the first time described the views on obsessions and compulsions in psychiatric literature. Earlier, obsessions were generally considered as the indicators of depression or melancholy. The view of obsessive compulsive neurosis had shifted towards a psychological explanation at the beginning of the 20th Century. Freud in 1909 published his first paper on the psychoanalysis of obsessional neurosis, where obsessive and compulsive behaviors were seen as the outcome of unconscious conflicts, thoughts, and behavior being isolated from their emotional components. The year 1950 marked the gradual emergence of behavior therapy, Learning principles are helpful not only in the conceptualization and management of phobia but also in treating the obsessive thoughts and compulsive behaviour. Later on, Cognitive Behavior Therapy (CBT) emerged as one of the effective intervention strategies for the management of OCD.

2. DIAGNOSTIC CRITERIA FOR OCD

According to ICD-10 (WHO) criteria "the essential features OCD are recurrent obsessive thoughts or compulsive acts. Obsessional thoughts are ideas, images, or impulses that enter the individual's mind again in a stereotyped form. Compulsive acts or rituals are stereotyped behaviors that are repeated again and again. They are not inherently enjoyable, nor do they result in the completion of inherently useful tasks. The individual often views them as preventing some objectively unlikely event, involving harm to or caused by himself or herself. Autonomic anxiety symptoms are often present, but distressing feelings of internal or psychic tension without obvious autonomic arousal are also common. There is a close relationship between obsessional symptoms, particularly obsessional thoughts, and depression. Individuals with obsessive compulsive disorder often have depressive symptoms, and patients suffering from recurrent depression may develop obsessional thoughts during their episodes of depression. In either situation variation in the severity of the depressive symptoms is generally accompanied by parallel changes in the severity of the obsessional symptoms.

Obsessive Compulsive Disorder is equally common in men and women, and there are often prominent anankastic features in the underlying personality. OCD begins in childhood or early adult life. The course is variable and more likely to be chronic in the absence of significant depressive symptoms.

For a definite diagnosis, obsessional symptoms or compulsive acts, or both, must be present on most days for at least two successive weeks and be a source of distress and it interferes with activities. The obsessional symptoms should have the following characteristics; (a) they must be recognized as the individual's thoughts or impulses (b) there must be at least one thought or act that is still resisted unsuccessfully (d) the thought of carrying out the act must not in itself be pleasurable (simple relief of tension and anxiety is not regarded as pleasure in this sense), (e) the thoughts, images, or impulses must be unpleasantly repetitive" (ICD-10, WHO, Indian edition, 2007).

In the fifth edition of the Diagnostic Statistical Manual (DSM-V), "the diagnostic criteria for OCD are as follows: There must be a presence of obsessions, that means recurrent and persistent thoughts, urges, or images that are experienced, at some time during the disturbance, as in intrusive and unwanted, and that in most individuals experience marked anxiety or distress. (2) The individual attempts to ignore or suppress such thoughts, urges, and images to neutralize them with some other thoughts or actions (i.e., by engaging in some compulsive acts). Again Compulsions are defined as repetitive behaviors (e.g., hand washing ordering, checking) or mental acts (e.g., praying, counting, repeating words silently) that the individual feels driven to perform in response to an obsession or according to rules that must be applied rigidly. The behavior or mental acts are aimed at preventing or reducing anxiety / distress, and preventing some dreaded events or situations; however, these behaviors or mental acts are not connected in a realistic way with what they are designed to neutralize, prevent, and are clearly excessive. The obsessions and compulsions are time-consuming (e.g., take more than one hour per day) or cause clinically significant distress or impairment in social, occupational, or other important areas of functioning. The obsessive compulsive symptoms are not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or other medical conditions. The disturbance is not better explained by the symptoms of another mental disorder (e.g., excessive worries, as in Generalised Anxiety Disorder; preoccupation with appearance, as in Body Dysmorphic Disorder; difficulty in discarding or parting with possessions, as in

Hoarding Disorder; hair pulling, as in Trichotillomania, skin picking, as in Excoriation Disorder; stereotypies, as in Stereotypic Movement Disorder; ritualized eating behavior, as in Eating Disorder, preoccupation with having an illness, as in Substance-related and Addictive Disorder; preoccupation with having an illness, as in Illness Anxiety disorder; sexual urges or fantasies, as in Parapaphilic disorder; impulses, as in disruptive Impulse control and Conduct Disorders; guilty rumination, as in Major Depressive Disorder; thought insertion or delusional preoccupations, as Schizophrenic Spectrum and Other Psychotic Disorders; or repetitive patterns of behavior, as in Autism Spectrum Disorder)", (DSM-V, 5th edition, 2013).

4. COGNITIVE BEHAVIOR THERAPY

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

The aim of CBT is to allow an individual to manage his or her problems in a way that future problems are dealt with in an adaptive way. Mohney (1993) has described CBT as the commitment to self-examination, and selfawareness. Cognitive Behavior Therapy is not only applicable to people with mental health problems and it is also effective to help people in coping with relationship difficulties, physical health problems, and pain management, etc. In all these areas the main objective is to manage their lives adaptively by recognizing the interaction between thoughts, feelings, and actions or behavior. Another objective of the CBT is the minimal exertion of control of the therapist and empowerment of the client to be able to cope with his or her problems. This is achieved by helping the patient to recognize the relationship between his/her thought, feeling, and behavior. In this way, the patient will be able to influence the way he or she feels, by modifying the way he or she thinks about events. At the end of the CBT intervention, the patient should be competent to recognize and manipulate the relationship between thoughts, feelings, and behavior.

4.1 Fundamental Postulates of CBT

CBT explains three fundamental postulates which include a) cognitive activity affecting behavior, b) cognitive activity may be monitored and altered, c) desired behavior change may be affected through cognitive change. The first fundamental postulate of CBT states that cognition affects human behavior which is a summary of the basic meditational model. Now a days theorists have started emphasizing cognitive appraisal as it is affecting the response to the event and their importance in changing the content of those appraisals, unlike earlier emphasis that was only on empirical and theoretical authenticity of the meditational proposition.

The second postulate of CBT gives emphasis to monitoring and alternation of cognitive activity. This statement presumes that we may earn access to cognitive activity and that cognitions are assessable. The active cognitive assessment investigators pursue their research to develop approaches comprising of both reliable and valid cognitive evaluation tactics by considering behavior as an originator of behavioral data. The face value report of cognition is usually taken into consideration the majority of the time which accounts for biasedness and requires further validation.

Another inference stemming from the second postulate of CBT is that the assessment of cognitive activity leads to commencement and transformation of it. However, while measuring a construct the researcher might land up in manipulating it thus affecting the sequential order of previous constructs. Most of the cognitive assessment focuses on the content of cognition and their assessment shows cognitive process lag. Investigating and reviewing the process of cognition as well as the consanguinity between cognitive, affective, and behavioral systems, will most likely head its way to our comprehension of change. But this model of cognitive monitoring remains largely underdeveloped when the assessment of cognitive content is taken into comparison.

The third postulate of CBT deals with the notion that, the desired behavioral change may be effected through cognitive change. Thus while cognitive behavior theorists agree that overt reinforcement contingencies can bring about behavior modification, they are likely to focus on the available alternative methods available for behavioral change, one particular being the cognitive change.

CBT is an umbrella term of empirically supported psychological intervention for clearly defined psychopathologies that are targeted specific treatment strategies. In the field of

psychotherapy, CBT is one of the most effective psychological interventions. CBT is the first psychotherapy that is largely evidence- based besides other types of psychological interventions are not practically superior to CBT in any way, the models of CBT or mechanisms of change have been the most empirically validated and it is the widely accepted paradigm of the human mind and behavior.

4.2 obsessive compulsive disorder and Cognitive Behavior Therapy

The psychological interventions have been shown to be effective in the management of OCD since the last two to three decades. After, the emergence of CBT intervention the prognosis of OCD has changed from poor to good. Cognitive Therapy in CBT refers to specific methods and techniques that help to change irrational beliefs and ideas, including those prevalent in OCD.

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

Assumptions of Cognitive Behavior Therapy for OCD. CBT for Obsessive compulsive disorder is focused on assumptions based on various theories. Those are described below.

- **Normalizing Unwanted Intrusions.** One of the primary aims of CBT is to make the client realize that his/her suffering is because of the importance he/ she attached to particular thoughts which are unwanted and intrusive in nature, rather than to the occurrence of this content of thoughts. The therapist by using the cognitive- behavioral model educates the clients that the unwanted interfering thoughts, images, and impulses which are not acceptable by the ego are universal. Hence, obsessions are a severe type of normal unwanted thoughts.
- **Role of Faulty Appraisals**. One more goal of CBT for OCD is changing the faulty appraisal which is regarded as an essential component in the endurance of obsessive

thoughts. In obsession, faulty appraisals matter a lot as they are building on overemphasis and callous persistent priority that is given to the intrusive thought which are deemed as unwanted.

- **Differentiating Appraisals from Obsessions**. It is important to differentiate the intrusive (obsessive) thought from the subjective meaning assigned to that particular thought (i.e. the appraisal). The change of faulty appraisals is centered on the idea that individuals with OCD can be guided to discriminate between the obsessive thoughts and their appraisal (meaning). Whittal and McLean (1999, 2002) opined that clients often find it hard to grab the concept of appraisal. Cognitive-behavior therapists used to explain obsession in terms of the weightage assigned to the intrusive thoughts, or what the individual conceives about obsessive thoughts and their significance.
- **Role of Neutralization**. CBT aims to have the person do nothing in reaction to the obsession or to intentionally attend to the obsession. Further, it suggests that a person should not engage in cognitive dismissal or avoidance tactics to reduce or eliminate his/ her obsessive thoughts as well as suffering. To decrease the frequency and distress of obsession, the CBT theorists identify that avoidance or safety-seeking behavior, reassurance-seeking behavior, compulsive behavior, and other neutralizing strategies have to be eliminated.
- Excessive **Mental Control**. The target of Cognitive Behavior Therapy is to motivate or help the individual to choose a rational or positive attitude toward obsessive thoughts and give away any effort to control his or her unwanted intrusive thoughts. Persons who are suffering from OCD give excessive effort to check unwanted intrusive thoughts, and so they attempt too hard to excerpt mental control over their obsessions. This can lead to a preoccupation with attaining better mental control. Often the persons with OCD consider that their major issue is deficient mental control, whereas the CBT practitioners explain the disorder in a different way. They feel that the problem is excessive mental control.
- **Core Dysfunctional Beliefs.** The last assumption in CBT for OCD is the primary role of particular dysfunctional beliefs and assumptions in the etiology and maintenance of obsessive thoughts. Although, CBT gives emphasis to the demand to modify faulty appraisals and dysfunctional beliefs associated with obsessive thoughts but the difference between the two is not clear. The hidden assumption is that CBT targets faulty appraisals

which will have an impact on the specific dysfunctional belief that supports a faulty appraisal. Throughout the course of CBT treatment of obsession, related appraisals and beliefs occur concurrently.

4.3 Basic Techniques of CBT

The model of CBT for the therapeutic intervention of OCD is systematic and brief as well as it helps clients to manage obsessive compulsive symptoms. This is usually done through the application of cognitive and behavioral techniques. Some of these techniques involve psycho-education, repeated exposure to fear stimuli and response prevention, challenging dysfunctional beliefs related to obsessive compulsive symptoms, symptoms monitoring, and homework assignment. CBT typically lasts ie 13-20 15 sessions if OCD is not associated with any co-morbid disorder.

Generally, CBT is held on once or twice a week. ERP is a behavioral technique that is the most widely used intervention technique in the management of OCD. Although ERP is very effective, clients often face obstacles with the demand of ERP which may be responsible for poor compliance to treatment with noticeable high drop-out rates. The next sections will discuss the commonly used techniques of CBT that are psycho-education, ERP, and cognitive exercises.

1) Psychoeducation. Psychoeducation is the initial step of CBT which is highlighted by numerous clinicians and researchers. There are two important goals of psychoeducation: a) "to normalize the experience of unwanted intrusions and b) to provide a treatment rationale" (Clark, 2007).

i) Normalizing Unwanted Intrusion. The therapist initiates the procedure of modifying the person's perception of his or her obsession by normalizing the occurrence of undesirable disturbing images, impulses, and thoughts after identifying the primary obsessions. As repeated disturbing thoughts, impulses and images preoccupy the minds of the clients with OCD, most of the clients believed that they are not normal. So, the therapist here clarifies that the majority of individuals (90%) state that they often encounter unwanted intrusive thoughts of sex, religion, dirt, contamination, aggression, accident, mistakes, making embarrassing remarks, dishonesty cause injury to self or others and lose control which is distressing in nature. At times the thoughts and images of this nature are activated by specific stimuli, such as dirt

and contamination, having the thought of causing harm to others, etc. but at other times they appear all of a sudden. Making the Clients aware of the fact that such experiences are not uncommon in nature can cast a positive therapeutic impact, and also this can serve as the first positive message that the clients have heard about their obsessions that numerous other individuals have equal mental experiences.

ii) ***Explaining the Role of Appraisals***. After normalizing unwanted intrusive thoughts, the next educational component of CBT is explaining the role of the appraisal to the client. Here the therapist may convince the client that they have seen in reality, every person experiences unwanted intrusive thoughts. Certain specific intrusive thoughts can become more frequent and distressing for some individuals but for others, it may be rare and meaningless. The therapist then chooses one unwanted thought that an individual has encountered infrequently but it is neither certainly distressing nor likely to lead to a neutralizing behavior. The therapist and client employed the CBT model to work collectively in a constructive manner to find out probable responses to the identified negative disturbing thoughts which cause continuous distress to the client. The patient must observe how his or her behavioral and cognitive response to non-distressing and negative intrusive thoughts can turn it into a highly disturbing cognitive phenomenon. Furthermore, the therapist clarifies to the client that he or she may also encounter many negative thoughts that occur low in number but can have positive reactions.

iii) Role of Neutralization. Another important component of CBT is to introduce the patient to the counter-productive effects of different mental control strategies and neutralization. Freeston and Ladouccer (1997) explain a behavioral experiment called the "camel effect" to show the ineffectiveness of the attempt to deliberately suppress or remove unwanted intrusive thoughts or obsessions. The objective of this mental control strategy is to make the patient experience the negative impact that intentional mental control and other neutralizing behavior have on the frequency and distress of unwanted thoughts.

2. Treatment Rationale. The therapist explains the treatment rationale once the client comprehends the cognitive-behavioral model of their obsessions. The therapist informs the client that CBT will focus on facilitating the client to modify his or her reactions to the obsession. Treatment involves a variety of intervention strategies that explores different manners to understand or interpret the obsessive thoughts so that the client gives no significance or personal meaning of occurrence. Mainly there are two targets of therapy.

The first target of therapy is to assist the client to perceive that obsessive thoughts are less threatening. The second target is to develop diverse approaches to react to obsessive thoughts, to decrease neutralizing behavior, compulsive acts, and other cognitive dismissal and mental control strategies.

3. Exposure and Response Prevention (ERP). The first case study on the use of ERP to treat OCD was published by Victor Meyer in the year 1966. ERP is a time-tested method and also the first-line choice of treatment for OCD. The strategies gripped in ERP are 1) intentional exposure to all previously avoided situations; 2) direct exposure to feared stimuli (including thoughts); 3) prevention of compulsive rituals and neutralizing behaviors, including covert ones (i.e. response prevention). Generally, this technique consists of preparing a graded structure of feared stimuli in which the fear-producing stimuli are arranged from low to high. After that, the client is exposed to the feared stimuli which are arranged in a graded manner one after the other till the high fear-producing stimulus is resisted by the client while simultaneously practicing response prevention where the client is taught to eliminate anxiety or distressing emotional reaction and asked to refrain from engaging in compulsive behavior. Numerous researches proved that ERP is one of the successful intervention techniques for the management of OC symptoms. The success rate of ERP treatment is approximately 80% and usually, gains from the treatment are also maintained for a long period. The various meta-analysis and numerous clinical trials showed that ERP is equally effective or marginally more effective as compared to SSRIs. In clinical practices, if the obsessive and compulsive symptoms have a mild level to moderate level of severity ERP is the first preference for the management of compulsive rituals.

4. Cognitive Restructuring. Cognitive restructuring is the method of modification of thoughts (the way one appraises and makes sense of events). Thus, it brings changes in the mood of the person. It uses a set of cognitive intervention techniques for becoming more aware of and modifying them. Changing cognition is a gradual process. It involves awareness, reappraisal, generating alternate/ adaptive response, adoption, substitution, and evaluation. It is very difficult to alter one's cognition. In OCD, cognitive restructuring helps the client in two ways: firstly, it helps the client to see that they have choices to interpret their thought and how it is making difference in the level and intensity of OCD symptoms. Secondly, by increasing awareness of the faulty ways, clients interpret their thoughts and become more objective about

them, rather than overreacting towards them. Socratic questioning is a cognitive restructuring technique widely used in clinical practice to change the client's dysfunctional belief about obsessive compulsive symptoms. This technique is explained below.

***Socratic Questioning*.** Socratic Questioning consists of multiple CBT interventions that are aimed to open the minds of clients who are stuck in a limited and negative way of seeing the world by helping them to be aware of other perspectives. Socratic questioning aims to facilitate the client's ability to look at things from a new angle. In Socratic questioning, systematic questioning and reasoning are used. A common sequence of four steps can be deduced from the way various authors analyze the process i) Asking informational especially analytic and evaluative questions to discover information outside the client's present awareness. ii) Active listening along with empathetic reflection. iii) Summarising discovered information. iv) Inquiring synthesizing questions that facilitate the application of the new information discussed to the client's original belief or thought.

Socratic questioning is used to probe thoughts related to problematic emotions and behavior. Generally, the questions asked in Socratic questioning are a) What is the evidence to support the thought? b) Are there any alternative interpretations? c) Am I totally responsible for this negative event, and can I do anything about it? And d) what if my interpretation is true? How will I manage then?. Through these questions, the degree to which particular thoughts are biased or exaggerated, whether they do reflect a real difficulty or skill deficit and how the patient can best cope up with the worst- case scenario can be elicited.

5. CONCLUSION

Obsessive-Compulsive Disorder is a significant mental health issue in India, affecting millions of people. Despite the challenges posed by cultural stigma and limited access to mental health services, there is hope for individuals with OCD through effective treatment and support. By increasing awareness, promoting early intervention, and integrating traditional practices with modern medicine, we can improve the lives of those affected by OCD and create a more understanding and supportive society.

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