Obsessive-compulsive disorder: case study and discussion of treatment

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SUMMARY. A patient's own account of her obsessive-compulsive disorder is presented. She describes her distressing experiences, the impact of the disturbance on her and her family's life and her subsequent improvement using the technique of exposure and response prevention. The treatments available are discussed and the benefits of self-directed behavioural psychotherapy are reviewed. A comment from a general practitioner is appended.

Introduction

OBSESSIVE-compulsive disorder accounts for between 0.1% and 4.6% of psychiatrically disturbed individuals.[1] However, minor obsessional traits are observed far more often, being found in 14% of a sample of normal people in the United States of America.[2] A genetic predisposition seems likely, since obsessionality is more prevalent in first degree relatives of obsessive-compulsive patients than in the population at large.[3] Furthermore, monozygotic twin pairs show frequent concordance for symptoms of obsessive-compulsive disorder compared with a virtual absence of concordance in dizygotic twin pairs.[4] Neurological factors may occasionally contribute to the disorder. However, they are present in only a minority of cases. Successful behavioural treatment is independent of such factors.[5] The outlook for sufferers is variable and depends on the severity and duration of disturbance. Seventy per cent of mild cases improve substantially after one to five years although only 33% of hospitalized patients improve over a similar time period.

Despite the existence of copious literature on the management of obsessive-compulsive disorder, there remains uncertainty about its nature and there are disputes as to the relative usefulness of the various treatments available. The most popular physical treatments, antidepressants such as clomipramine and fluvoxamine, have been superior to placebo in relieving obsessive-compulsive symptoms but relapse is a problem.[6] Dynamic psychotherapy has little part to play in the treatment of this condition.[7] No adequately controlled trials of such therapies for obsessive-compulsive disorder exist. Indeed, Freud himself regarded obsessive-compulsive neurosis as very resistant to, if not untreatable with, psychoanalysis. Self-exposure and self-administered prevention of rituals is superior to other psychological treatments, and improvement has continued to four year follow-up.[8] This seems to offer the best chance of success.

This paper aims to create further understanding of this disabling disturbance and to provide an outline of effective treatment by means of the personal account of an individual who has suffered from it.

JK was a 31-year-old teacher who lived with her husband in Cambridgeshire. On referral to the behavioural inpatient unit of the Bethlem and Maudsley hospitals she had had intractable obsessive-compulsive disorder for six years. It had developed suddenly, rapidly intensifying to a point where it devastated both her and her husband's life. There were no significant findings in the family or personal histories; her marriage had presented no problems, apart from her fear of pregnancy. She had failed to respond to medication, hypnotherapy or protracted individual and group psychotherapy. Following admission to the Bethlem Royal hospital, she made an impressive response to a behavioural exposure therapy programme, and her gains were subsequently well maintained in her home environment over the next two years, after which she relapsed somewhat and had to resume treatment.

A personal account

'I have always been a worrier, but it did not start to ruin my life until seven years ago. I was 24 years old, a teacher, and happily married.

'The first attack occurred during a childrens' church service. I joked to Joe about one of the children present. It was not nasty, but it started to play on my mind. I became anxious that the child's parents, sitting nearby, had heard me and misinterpreted it. My thoughts rapidly expanded. The parents would be annoyed and report me. I would be reprimanded and dismissed from the school. The story would be in national newspapers. I might be sent to prison. Joe tried to reassure me, but I could not believe him. I felt wicked. I deserved to be punished. From then on I monitored my speech carefully, being unable to converse unless I was at home with the windows shut. My problems started with panic leading to avoidance, checking and rituals, to stop the situation recurring.

'Anxiety escalated while cleaning the toilet. I noticed the instructions on the bottle, not to let the bleach mix with other varieties. I wondered if there was old bleach in the pan. Had they mixed? Would there be fumes? Might they enter the sewers? Could I blow up Britain's drainage system? After this I avoided using bleaches and lavatory cleaners, and then more cleaning agents. I became terrified of them and felt a need to wash my hands if I saw them.

'I became obsessed with dirt and cleanliness. I washed my hands 100 times a day as indicated by my bleeding knuckles. I washed 40 tea towels at a time. I thought lice were living on my body, and itching reinforced my fear. I examined the bed at night, making sure there were no insects. I was petrified of contaminating people, thinking they might die. I wanted to wash anything I touched. I even had to buy items in shops simply because I felt I had contaminated them. I threw away food for fear of poisoning people. I became so obsessed with colours and smells that I could no longer trust my own judgement, and pestered Joe for constant reassurance. I avoided supermarket freezer sections in case I damaged them or unfroze the food, leading to peoples' death from salmonella poisoning.

'Prescribed tablets became yet another nightmare. I was convinced I would lose them and that children would eat them. I felt sure the tablets were everywhere, in handbags, clothes, even

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Submitted: 16 May 1989; accepted: 23 October 1989.

shoes. Dressing became laborious with all the checks; I sometimes had to stand on the bed so pills on the floor would not stick to my feet. Few people were allowed in the house. When they left I had to check the soles of their feet and shoes for pills.

'I could not leave the house by myself in case I left electrical items or taps on. I could not use trains for fear of not properly closing the carriage door. I could not read newspapers or watch television as doing so triggered thoughts and memories. I could not work. I constantly asked Joe for reassurance of his love and fidelity but would not believe him anyway. We argued and were irritable. I became even more anxious about becoming pregnant, and we agreed not to make love for three months — the 'danger' period following a rubella injection I had had. Thereafter I wore underwear in bed and asked Joe to do the same. For extra protection I started to sleep in a sleeping bag on top of the bed. I would not dry myself on towels Joe had used, or use the toilet directly after anyone else. I was terrified of catching pregnancy.

'I saw two psychiatrists and a psychologist, had hypnosis, and abreaction after injected drugs. I spent hundreds of hours discussing the past and present. I was prescribed numerous medicines and had had a weeks' psychiatric inpatient stay. I had had years of group therapy. Then my general practitioner suggested behavioural psychotherapy. Reading Professor Marks' book *Living with fear*[9] produced relief and excitement. There were people who actually thought similarly to me. I could now accept my problems more as an illness. I grasped the general concept of exposure treatment fairly easily. If you avoid something, you should do it, cut out checking, cut out reassurance, and live life by taking risks. Easy to say, not easy to do. Joe would not be allowed to reassure me.

'I arrived in hospital with determination, hope and desperation. I talked as honestly as I could about my problems. Thinking they were somebody else's too made it less embarrassing. Treatment required that I make myself as anxious as possible and stay with it, instead of pushing it down with checking and reassurance. Eventually the message started getting through; anxiety cannot last indefinitely, it does begin to go away. Numerous tasks were constructed that would provoke anxiety and get me used to facing it. When I read the list I cried.

'Slowly I came to terms with the programme. I was allowed to wash my hands only five times a day. What happens if I run out by lunchtime? Hard luck was the reply. I went round freezer cabinets for an hour a day moving frozen food around. I used water taps and electrical appliances daily and left them without checking. I cleaned the baths and sinks daily with previously avoided Jif, working to a strict time schedule. I had to rub Jif into my hands and then rub all the door handles with it. I hated that, particularly rubbing the door handle of a pregnant patient. In temper I rubbed the nurses' door handles so they had the worst, rather than the unsuspecting patient.

'I had to make the patients' tea. Using kettle and taps provoked anxiety, and I feared poisoning with my dirty hands. Once I thought I had accidentally put bleach into the tea. I only just managed not to throw it away.

'I had to use a handbag that I had avoided touching for years because it had once contained tablets. Loose drawing pins were put in it and then a bottle of pills. I felt contaminated just looking at them. The first time I went out I gripped the bag so tightly my hands became red and marked, but slowly, with practice, it became easier.

'The progamme was difficult and exhausting, despite its novelty and my enthusiasm. Later it became harder to keep going. Joe and I stayed in the flat on the ward to simulate a home environment. I cooked, cleaned and slept there without a sleeping bag. Sunday dinner was roast chicken — frozen, of course. Each time we left the flat I had to do a quick check of taps, plugs, switches and so on, not Joe. Joe was trained how to handle me. He had to act as exposure co-therapist when I was away from hospital.

'As things became easier, I suggested and added more difficult tasks. I appreciated having them modelled by nurses, as often I had forgotten what 'normal' people did. I hesitated when asked to perform one task. The nurse said to me 'Do not think about it, just do it' — a sound piece of advice.

'Three months later it was becoming easier. Unexpected incidents were the worst. I knew then that the way to deal with them was to accept the anxiety, accept that what you fear might happen, and then endure a bad couple of hours, after which the anxiety began to fade. I got fewer unexpected fears. Sometimes the thoughts were weaker than they once would have been. Reassurance did not work. My brain had a way round it and demanded more and more. I did things now that I would never have thought possible six months before. I cleaned the house and put bleach in the lavatory. I cooked regularly. I shopped for frozen foods. I took more risks, especially with what I said. Joe and I had made love a few times, after more than a year's abstinence. I went for a job interview. I felt more confident. I realized there was still quite a way to go, but I felt I was on the way.

'A year later life had changed significantly. I had gained a temporary job — on the medicine counter of a large store. Later I assisted in a children's shop and was offered promotion. I no longer worried about children entering my house. Joe and I made love regularly. Pregnancy fears persisted, but could be controlled. I knew then what to do. My life was considerably better.

'It is now three years since I started behavioural therapy. The last year has been quite difficult without constant hospital support. I know the techniques, but energy and enthusiasm are sometimes a problem. I still feel the treatment was worthwhile, the most effective I have received. I now work and function in a way I considered impossible before the hospital admission.'

Management of obsessive-compulsive disorder

The usefulness of behavioural techniques in the management of obsessive-compulsive disorder has been apparent since the 1960s. Meyer[10] demonstrated an impressive 90% success rate for symptom alleviation in a series of case studies, using a combination of flooding and response prevention. A 70% success rate was achieved in subsequent controlled studies.[11] The treatment package comprised three important therapeutic factors:

- Exposure: the patient confronts the anxiety-provoking situation or object (for example, contamination).
- Response prevention: the patient subsequently refrains from undertaking his or her usual anxiety-reducing rituals (for example, compulsive hand washing).
- Modelling: the therapist models appropriate behaviour and responses for the patient to follow.

Peck and MacGuire[12] have described the management principles in greater detail. They emphasized that therapy sessions should last at least one hour — that is until anxiety has diminished. It is now acknowledged that therapy sessions need not be so protracted. Extensive supervision is not necessary; simple instructions should be sufficient. It is the patient's own practice which is important. This exposure enhances the generalization of beneficial responses to a variety of settings. Both therapist and client should be aware that progress is likely to be gradual, with different aspects of the problem changing at different rates. Reassurance must be avoided as this serves only to increase the problem.

Exposure programmes are of specific therapeutic benefit even when the expectations of patients and the variations in individual therapists have been taken into account. In one study[13] a group

of patients were led to believe that they would improve with 'anti-exposure'. Explanations were provided such as 'If you are frightened of something and it worsens your rituals, steer clear of it at all costs.' These patients failed to improve. Thus, improvement from self-exposure is mainly to do with the component of exposure that causes anxiety to subside, rather than the expectation of improvement.

Marks and colleagues[14] have recently undertaken a controlled trial of clomipramine, self-exposure and therapist-aided exposure for obsessive-compulsive rituals. Clomipramine produced only transient improvements in some measures of rituals and depression, even when drug therapy was continued. Instruction about self-exposure produced significantly more patient improvement than did instruction about anti-exposure. Adding therapist-aided exposure to self-exposure after eight weeks had a barely significant, transient effect of dubious clinical value. The authors concluded that self-exposure was the most potent of the techniques they studied, with clomipramine providing a limited adjuvant role. Therapist-aided exposure had only a marginal role, though it sometimes proved crucial in severe refractory cases.

Another big advantage of behavioural methods is that they form a system of self-help that the patient learns from the clinician who largely acts as coach and monitor.[8] Behavioural treatments do not require a detailed knowledge of learning theory, the methods are time-effective, and they can be readily applied in primary health care settings. The challenge to the clinician is to persuade the patient to engage in self-exposure and self-imposed response prevention. Therapist-aided exposure needs to be added only for those exceptional cases who cannot start on their own. The general practitioner can play a crucial role in this respect, educating the patient, monitoring progress, and providing feedback, encouragement and support.

Comment by a general practitioner

This vivid, detailed account of a patient and the reports of controlled trials of treatments for groups of patients, argue persuasively that behavioural therapy 'by self-imposed exposure and response prevention' is the method most likely in the long term to help people suffering from obsessive-compulsive disorders.

New cases of obsessive-compulsive disorder, as distinct from phobic states and other neuroses, may present to any one general practitioner only about once in three years. It is therefore difficult to comment on the basis of extensive first-hand experience. But, as the article shows, prolonged association with a single patient can still provide a valuable source of evidence. Description is still useful, indeed essential for understanding.

General practitioners are likely to see this disorder not only as rare but also as intractable. Many will therefore refer patients to psychiatrists, psychologists or, maybe, counsellors. If the decision is to refer, the choice of person to refer to rests with the general practitioner and this choice may determine the method of treatment used. Advocates can be found for the use of tranquillizers or antidepressant drugs; for psychological approaches which encourage avoidance or which encourage exposure, or which pursue past and present causes for anxiety; and perhaps even for the use of one of the many complementary therapies.

My own limited experience supports the view expressed in this article that self-imposed response prevention is indeed the form of treatment likely to help sufferers in a lasting way. But the different therapeutic techniques available are not necessarily mutually exclusive. Antidepressant drugs also help — more often than the case here described would suggest and especially if there is good evidence of depressed mood. Tranquillizers have only a very limited application. It is also prudent, as a preliminary, to survey and discuss with the patient possible causes of anxiety which may act as triggers, even if the systematic extension of this principle into total therapy seldom proves helpful.

If the right therapist is to be found, it is important for general practitioners to understand the essentials of response prevention and 'exposure'. Moreover the patient may well seek the general practitioner's support during what is likely to be a very exacting experience.

This article implies that referral may not always be necessary and that in some instances a general practitioner can supply all that is needed. I am less optimistic. Unless phobias and obsessional disorders happen to be an area of special interest, their rare incidence offers too little chance for the general practitioner to develop experience and the confidence to deal with them, even though the technique may be fairly easy to learn. Furthermore the time needed for initial instruction and continuing support inevitably competes with many other claims. Sadly, it is not possible for any one general practitioner to use all the techniques which his or her patients can benefit from and which are therapeutically manageable in a primary care setting.

A large group practice, however, may provide enough examples of this disorder for one general practitioner member to develop a special interest in obsessional states. Even more promising is a practice to which a community psychiatric nurse is attached or which is visited regularly by a psychiatrist or psychologist. However, it cannot yet be assumed that any of these professionals accept exposure and response prevention as the best method of treatment or are competent to use it unless they have made a special effort to become so.

The patient who describes her experience in this article reached effective treatment late. Most patients with obsessive-compulsive disorder will feel ashamed and so will be reluctant to come for help. General practitioners are in a position to see that this does not happen — to recognize and act earlier, but also to make it easier for these patients to sense that if they come for help they will be listened to and understood.

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