Pragmatic Case Studies in Psychotherapy, http://pcsp.libraries.rutgers.edu
Volume 9, Module 1, Article 4, pp. 81-97, 02-17-13 [copyright by authors]

"Functional," Sub-Clinical Obsessive-Compulsive Symptoms and Their Challenges: The Case of "Angela"

LIVIA M.M. PONTES[a,c] & RODRIGO F. PEREIRA[b]

[a] Department and Institute of Psychiatry, University of São Paulo Medical School, São Paulo, Brazil
[b] Department of Clinical Psychology, Institute of Psychology, University of São Paulo, São Paulo, Brazil
[c] Correspondence regarding this article should be addressed to Livia M.M. Pontes, Hospital das Clinicas da Faculdade de Medicina da Universidade de Sao Paulo, Rua Ovidio Pires de Campos, 785 05403-010—Sao Paulo—S.P., Brazil
Email: livia@liviapontes.com

ABSTRACT

Complex behavior patterns may underlie symptoms of obsessive-compulsive disorder (OCD), which, in turn, seem to contribute to the maintenance of symptoms, hinder its management, and interfere with the client's compliance with treatment. Although the evidence-based choice for treating OCD is cognitive-behavior therapy (CBT), such treatment might prove ineffective if it is not accompanied by a careful and thorough investigation of the contingencies involved in the onset and maintenance of symptoms; and this might take longer than predicted by treatment manuals. We present a case study of the treatment of "Angela," a client with OCD who suffered from sub-clinical symptoms for 20 years and did not obtain relief with antidepressant medication. Angela underwent cognitive-behavioral therapy for three and a half years and was treated by the first author in weekly sessions. The difficult management of symptoms, the contingencies involved in them, and the development of the therapeutic relationship are discussed. Treatment results indicated a significant decrease in symptoms, anxiety, and discomfort. We believe this case illustrates limitations associated with a strict, manual-driven treatment with a pre-determined number of sessions.

Key-words: obsessive-compulsive disorder (OCD); cognitive-behavior therapy; contingencies; therapeutic relationship; exposure and response prevention; cognitive re-structuring; case study; clinical case study

1. CASE CONTEXT AND METHOD

This article aims to present the case of "Angela," a client diagnosed with OCD, who had sub-clinical sexual and contamination obsessions and cleaning rituals, in order to illustrate the development of the cognitive-behavioral treatment, especially the contingencies involved in the maintenance of symptoms, the difficulty in managing them, and the importance of the therapeutic relationship to the development of treatment. Angela was treated by the first author, an experienced cognitive behavior therapist, in her private practice. The second author is also an experienced cognitive behavioral therapist with whom the development of the case was discussed in peer-supervision. The therapeutic program consisted of weekly sessions for three and a half years, including intervals of two or three weeks during holidays. The possibility of

Pragmatic Case Studies in Psychotherapy, http://pcsp.libraries.rutgers.edu
Volume 9, Module 1, Article 4, pp. 81-97, 02-17-13 [copyright by authors]

using data from the treatment for the publication of a case study was discussed with Angela. She was informed about all the ethical procedures and the safeguard of her identity and her written consent was obtained.

2. THE CLIENT

Angela was a 65 year old married female and retired occupational therapist who sought cognitive-behavioral therapy at the suggestion of her psychiatrist for OCD and depression issues. A number of years previously she had been diagnosed with OCD by the same psychiatrist with whom she had consulted because of memory difficulties. After retiring four years ago, Angela's routine became empty with no pleasurable activities and no special interests. Her remaining activities included private English lessons once a week and the weekly visit to her psychologist.

3. GUIDING CONCEPTION WITH RESEARCH AND CLINICAL EXPERIENCE SUPPORT

Cognitive-behavioral therapy (CBT) has become well-known as an approach with faster results (Milton, 2001; Hall & Iqbal, 2010) and shorter duration, (Hawton et al., 1989; Gaudiano, 2008; Hall & Iqbal, 2010), especially for clients with acute-phase psychiatric conditions. This may be caused by the tools used in therapy providing rapid relief from symptoms. The conception of CBT providing faster results seems to come from one central pillar of this approach: it is described as having a temporal limitation (Hawton et al., 1989), with protocol treatments proposing brief interventions, often around 12 to 20 sessions (Hawton et al., 1989; Whittal & McLean, 1999; Gaudiano, 2008). In this sense, CBT is sometimes considered a more superficial approach by some mental health professionals. In this view, it is seen as a mechanical, less complex model that falls short on therapeutic power, does not favor the investigation of contingencies surrounding the client's symptoms nor the client's emotions (Milton, 2001; Gaudiano, 2008), and does not place sufficient attention on the complexities and importance of the therapeutic relationship (Gilbert & Leahy, 2007). Even the training of cognitive-behavioral therapists has been criticized as lacking complexity and duration, and for not encouraging professionals to search for personal psychotherapy (Milton, 2001). The misconception of CBT being a "quick fix" tends to frustrate and surprise some mental health professionals when treatment takes longer than a few months.

Obsessive-Compulsive Disorder (OCD) is characterized by obsessive ideas and/or recurrent compulsive behaviors. It involves avoidance of situations that generate high levels of anxiety, accompanied by rituals (behavioral or mental) which bring relief from anxiety. These acts are excessive and not realistically related to what they aim to neutralize (ICD-10, 1993; DSM-IV-TR, 2000). The disorder follows a chronic, fluctuating course, with symptoms waxing and waning over time (Eichsted & Arnold, 2001). OCD symptoms may also interfere in the patient's sexual life, although the mechanisms of such interference are not completely known. However, women diagnosed with OCD and who present contamination obsessions evidence more avoidant and non-sexual sensuality behaviors compared to women with other kinds of obsessions (Aksara et al., 2001). In fact, a review of multidimensional OCD models found that high scores in the sexual/religious symptom dimension are associated with worse long-term

Pragmatic Case Studies in Psychotherapy, http://pcsp.libraries.rutgers.edu
Volume 9, Module 1, Article 4, pp. 81-97, 02-17-13 [copyright by authors]

response to selective serotonin reuptake inhibitors and cognitive-behavioral therapy (Mataix-Cols et al., 2005). Another study (Ferrão et al., 2006) found that the presence of symptoms of sexual/religious content and a chronic course are among the factors related to poorer treatment response.

Evidence-based treatments for OCD include pharmacotherapy and CBT (March et al., 1997; Stein, 2002; Abramowitz et al., 2003). CBT manuals, as well as clinical trials (Caballo,1996; Hawton et al., 1989; Whittal & McLean, 1999; Beck, 1991; Blackburn & Twaddle, 1996; Lidsay et al., 1997; Abramowitz et al., 2003) stress the importance of using specific and standardized techniques for each OCD symptom, as well as the efficacy of such procedures. The main procedure employed is exposure and response prevention (ERP). This approach is derived from behavioral principles such as systematic desensitization and habituation (Hawton et al, 1989). It includes the gradual and systematic exposure of the client to anxiety-generating factors and the non-execution of the rituals (Hawton et al., 1989; Gordon, 2002). Although symptom reduction is feasible and desirable, complete symptom remission is not always achieved and up to 50% of patients do not benefit from the treatment when taking into account rates of drop-out due to lack of response, refusal for treatment, or non-compliance (Keijsers et al,, 1994; Abramowitz, 1998; Whittal & Mclean, 1999; Vogel et al., 2006). Even when remission is defined as a reduction in symptoms (a score of 12 or less on the Yale-Brown Obsessive Compulsive Scale), 71% of patients did not reach it with 12 weeks of ERP nor with a combination of ERP and clomipramine (68%; Simpson et al., 2006) or with 17 sessions of ERP (Simpson et al. 2008).

Some studies have compared the efficacy of single procedures with either behavioral therapy, cognitive therapy, or rational emotive behavior therapy in the treatment of OCD; other studies have compared types of therapy in order to verify the superiority of an approach (Emmelkamp et al., 1988; Van Balkom et al., 1994; Van Oppen et al., 1995; Cottraux et al., 2001). However, the mere application of a technique or procedure without a full assessment of the underlying factors involved in the symptoms (i.e., what could be contributing to the development and maintenance of such symptoms) is risky, because it might not lead to the expected result, i.e., symptom reduction. According to Zamignani and Andery (2005), the employment of standardized procedures to the behavioral treatment of OCD is not consistent with an approach which analyzes and values the idiographic specificity of each client's behaviors. In other others, a "one size fits all" approach (i.e., concentrate treatment only on ERP) might hinder treatment, as each client is different, and a procedure that works well for one client, might be ineffective to another (Kohlenberg & Vandenbergue, 2007). Also, compulsions that are similar topographically (e.g., ritualized hand washing) might have different functions for two different patients (e.g., removing germs or reaching a feeling of evenness in both hands). Although ERP would be similar for both patients (avoiding washing hands), exposures would need to address different contents in order for it to be effective (Conelea, Freeman, Garcia, 2012). It is important that the practitioner carefully assesses why a procedure might not be working for a specific client and adapts treatment accordingly.

Although clinical trials understandably use a pre-determined number of sessions, which are relatively few for the treatment of these patients (and which is necessary to enable the study to terminate), setting a fixed term for therapy is quite challenging, because each client's

Pragmatic Case Studies in Psychotherapy, http://pcsp.libraries.rutgers.edu
Volume 9, Module 1, Article 4, pp. 81-97, 02-17-13 [copyright by authors]

evolution is unique and dependent upon many factors, such as the chronicity and intensity of symptoms, compliance and dedication to treatment, development of the therapeutic relationship, and the careful investigation and analysis of the contingencies involved in the client's complaints (Conelea, Freeman, & Garcia, 2012). This latter factor is, in turn, subordinate to the growing confidence that the client develops in the therapist and that enables him/her to expose his/her life story, which can take from a few weeks to several months—that is, it is subordinate to the therapeutic relationship/alliance.

4. ASSESSMENT OF THE CLIENT'S PRESENTING PROBLEMS, GOALS, STRENGTHS AND HISTORY

Presenting Problems

As mentioned above, the client Angela was a 65 year old married female and a retired occupational therapist who sought cognitive-behavioral therapy at the suggestion of her psychiatrist for OCD and depression issues. After an evaluation, Angela was diagnosed with OCD and depression, with memory difficulties being associated with these diagnoses. Albeit not feeling depressed, she consented to taking medication in the hope of obtaining some improvement in memory. Different antidepressants were tried until she started using clomipramine (250mg/day), although she observed no improvement in either her mood or memory with any of the prescribed medications. At the onset of psychotherapy, she had already been using clomipramine for eight years.

OCD symptoms manifested themselves essentially in relation to Angela's brother-in-law and had begun 20 years previously when they were all in her husband's car and she had witnessed her brother-in-law cleaning his nose with his index finger and wiping it on the car seat. When arriving home, she cleaned the entire car's interior with alcohol. Whenever she was visited by her brother-in-law or his family, or whenever she visited them, she had to clean all the places where they had been and had touched and had to change the clothes she had worn to their house. She did not describe concerns about a specific contamination from her brother-in-law and even verbalized that there was no threat of a real contamination. However, she felt everything he touched became dirty . A few months after this initial event, these symptoms became generalized and involved Angela's husband. She ended up avoiding touching his personal belongings (mobile phone, wallet, etc.), fearing that her brother-in-law might have touched these same objects. Whenever she greeted her brother-in-law or had any kind of physical contact with him, she felt as if it was somewhat "incestuous," in the sense that it was forbidden and had sexual connotations. These thoughts caused her distress, guilt, and the idea of having any sexual contact with him caused her to feel repulsed. In this sense, these thoughts can be categorized as sexual obsessions (Gordon, 2002). In the past, she felt the same in relation to her sisters' husbands and even her father, but she never performed any rituals. Such thoughts now persist only in relation to her husband's brother.

Angela would describe her brother-in-law as kind, attentive, and physically attractive, but she intentionally acted coldly towards him in order to avoid an increase in the frequency of his visits; the visits were rare as they lived in different cities. Other rituals emerged from that episode: changing into clean clothes whenever she got home, lying down in bed only in pajamas,

Pragmatic Case Studies in Psychotherapy, http://pcsp.libraries.rutgers.edu
Volume 9, Module 1, Article 4, pp. 81-97, 02-17-13 [copyright by authors]

avoiding touching furniture when wearing clothes she wore outside the home, sitting on the same spot on the sofa or the same chair at the dining and kitchen tables (thus ensuring she would not use the same seats as her husband), not using the television remote control (because her husband uses it), pushing the flat elevator's buttons with her car keys, and avoiding touching both the elevator's and her apartment's entrance door handles. These latter two rituals relate to the fact that her brother-in-law touched those handles when he visited her home. The client described these situations without distress and was aware that real chances of contamination did not exist. She did not actively avoid giving in to such rituals, although she anticipated some anxiety in trying. Interestingly, whenever she changed her outdoor clothes, she was able to put them back in the wardrobe without washing so she could wear them again.

Family History

Angela is the second daughter of a family of four (two sisters and a brother) and all her siblings are married and have children. She reports a distant relationship with her parents, practically without any physical contact, a rigid Catholic education (which included viewing sexual relations as "sinful" and "prohibited"), and being advised by her mother to be careful with men, as they would always somehow take advantage of women. She married when was 41 years old, after a year of dating and some hesitation, as she believed love would cease after marriage. Despite having dated before, she has only had sexual relations with her husband. They do not have any children.

Her husband was described as a good and gentle person, who seldom gets angry, but when he does he becomes rude and impulsive. He frequently demonstrated affection towards her, but she rarely reciprocated, and never spontaneously. This was explained by her as a way of not making herself too available and avoiding him "abusing" her. She resented the infrequent sexual contact after he had had his prostate removed, which made him impotent. A few years previous to this event, Angela started to doubt her husband fidelity after noticing some signs on different occasions: arriving home very late from a work party, a lipstick stain on his shirt, and carrying condoms in his briefcase. She confronted him many times until he finally confessed to having encounters with a woman, but only talking and never having sexual relations. Although she felt very hurt and resentful at first, fears of infidelity were dissipated after he became impotent.

She decided not to tell him her diagnosis, as she was confident he would disclose it to both their families even if she asked him to not to. She also feared that during a discussion he could use her diagnosis as a way of hurting her by calling her a "sick person."

Diagnosis

In order to determine the diagnosis, the Yale-Brown Obsessive Compulsive Scale (Y-BOCS) was applied (Goodman et al., 1989). This instrument pointed out the occurrence of sexually related thoughts ("What if I had sex with my brother-in-law?" "Would I have the courage to have sex with him?"), but she denied having any of the sexual obsession items. Those thoughts did not completely qualify as obsessions because they occurred only around three or four times a week, and remained in her mind for a few hours. Even though she felt guilty and sinful after having these thoughts, she did not feel the urge to perform any mental or neutralizing

rituals. Thoughts of a sexual connotation would come to her mind occasionally when she saw a man she considered physically attractive. Although such thoughts led her to feeling as though she was betraying her husband, which was described as a sin, she also did not perform any mental or physical actions afterwards.

In the category of "contamination obsessions," every sub-item was marked negatively (i.e., there were none, but she declared feeling disgusted by dirt or microbes). Nevertheless, such feelings were only sometimes present, occurring around two times a week or less. Moreover, she presented concerns with sacrileges and blasphemies, but such thoughts only occurred in specific occasions. For example, this would occur when an object fell on her feet or when she tripped over something, and she thought of foul words. Preoccupations with morality were also present, but such thoughts did not occupy her mind for extended periods of the day, nor did they bother her. No compulsions were present, but she felt she washed her hands too frequently, especially after greeting her brother-in-law and after she cleaned her husband's car whenever they visited his brother. Upon further investigation, she explained she washed her hands only once after the events, did not spend much time doing it, and it was not done in a ritualized manner. She did not report high levels of distress nor impairments due to these thoughts or behaviors.

Since these symptoms did not meet the DSM-IV-TR (2000) criteria for a full diagnosis of OCD, we diagnosed her with sub-clinical OCD symptoms. However, the fact that such thoughts generated discomfort and guilt, had been present for 20 years, and had motivated the client to seek therapy showed that the distress caused by them was worthwhile treating.

5. FORMULATION AND TREATMENT PLAN

Functional analysis (Haynes & O'Brien, 1990; Emmelkamp et al., 2007) of Angela's case raised the hypothesis that obsessive thoughts about her brother-in-law stemmed from her rigid concepts about her Catholic religion, which maintained her symptoms. It also indicated the hypothesis that the symptoms could have emerged from sexual feelings she experienced for her brother-in-law. Specifically, due to the rigid religious education the client had received, the cleaning rituals seemed to lower the discomfort levels raised by sexual thoughts towards her brother-in-law, allowing her to "purify" herself from such a "sin." Additionally, the fact that Angela had been deprived of sexual contact and missed it, the increasing distancing in her marriage, and the confirmation of her husband's infidelity in the past all seem to have contributed to the development of sexual obsessions, as outlined in Figure 1.

6. COURSE OF THERAPY

Angela was treated utilizing a cognitive-behavioral therapy approach throughout the three and a half years of psychotherapy. As the treatment took place in Brazil, sessions were conducted in Portuguese.

Cognitive-behavioral therapy has been found to be an effective treatment for OCD and its positive results have been described in many research studies and meta-analyses (Abramowitz, 1998; Abramowitz et al., 2002; Simpson et al., 2008). The main procedures employed were exposure and response prevention (ERP; Hawton et al., 1989; Gordon, 2002; Abramowitz et al.,

Pragmatic Case Studies in Psychotherapy, http://pcsp.libraries.rutgers.edu
Volume 9, Module 1, Article 4, pp. 81-97, 02-17-13 [copyright by authors]

2003); progressive muscular relaxation (Jacobson, 1948); diaphragmatic breathing (Hawton et al., 1989); and cognitive re-structuring (Beck, 1991; Blackburn & Twaddle, 1996).

ERP was used mainly to target the compulsions Angela presented; muscular relaxation and diaphragmatic breathing were employed initially to help Angela deal with anxiety symptoms and later on to motivate her to be more conscious of her body. Cognitive re-structuring was deployed to enable Angela to re-evaluate her very rigid conceptions about religion and marriage.

Initial sessions focused on psychoeducation, with explanations about the symptoms and course of the disorder, as well as the rationale-involving cognitive-behavioral therapy. After working with Angela to develop a hierarchy of difficulties, the ERP procedure was employed, beginning with imaginal exposure under my guidance, moving on to in-vivo exposure in my presence, both in the office setting, as well as outside it.

ERP started with Angela imagining touching avoided objects that were less anxiety provoking such as a small box she had received as a gift from her sister-in-law and a miniature boat her husband had received from his brother. Gradually, it progressed to in-vivo experiences with Angela bringing these objects to sessions and manipulating them for at least an hour and not washing her hands afterwards (up to 3 hours after sessions). ERP homework activities were also assigned, e.g., touching the elevator and flat door handles, touching the TV remote control, touching her husband's objects, and sitting on different spots on the sofa and dining table chairs. I highlighted that these exposures should be performed daily for at least one hour and that during this time and up to two hours afterwards Angela had to refrain from washing her hands or cleaning the objects.

Diaphragmatic breathing (Hawton et al., 1989) was also introduced, to teach Angela to cope with her anxiety. Angela did not experience high levels of anxiety with ERP, and she had difficulty in adhering to homework; the majority of the ERP activities were only done in my presence as the therapist, which rendered this procedure slow and not very effective. Proposals for increasing session frequency for a limited period, or the possibility of sessions in her home (since many anxiety-generating factors were there) were promptly rejected by Angela, on the basis that her husband could find out her diagnosis and that treatment costs would be too high. Even though I tried to overcome these obstacles by offering different ideas (proposing to schedule home sessions at a time her husband would not be at home and discussing prices and payment options), Angela still refused, with vague reasons (e.g., the cleaning lady who worked for her could tell her husband the therapist had been to her house and he would find out her diagnosis). Considering that her symptoms seemed to be sub-clinical, it had been expected that Angela would experience significant results with few months of treatment.

Hence, the facts described above indicated that there were possibly other underlying factors contributing to the maintenance of Angela's symptoms. After a year and a half of treatment and with little improvement, Angela revealed that her psychiatrist thought treatment was taking too long and she also felt the same way. The strong therapeutic alliance that had been formed enabled me to confront Angela, revealing that she had not been very dedicated to homework and that she had dismissed any attempts to increase treatment intensity. Angela was then asked if there were any factors that could be keeping her from fully committing to

Pragmatic Case Studies in Psychotherapy, http://pcsp.libraries.rutgers.edu
Volume 9, Module 1, Article 4, pp. 81-97, 02-17-13 [copyright by authors]

treatment. She recognized that she was not fully committed to treatment, and that she was not very concerned with obtaining a further decrease in rituals, as the rituals demanded no great rearrangement of her routine nor did they disturb it or occupy much time within it. Thus, the investment to obtain some improvement seemed too substantial and not worthwhile.

Determined to motivate the client, the focus of treatment was then modified. The procedures described above were retained, but sessions focused on clarifying and understanding other contingencies that would be involved in maintaining the symptoms and non-compliance with the treatment. A few months later, Angela identified that therapy was the only place where she could open up, talk about her problems, ask questions, and have some activity in her weekly routine. There were gains to be had, therefore, in maintaining her symptoms, as they would guarantee her permanence in therapy. Sessions were then dedicated to helping Angela reconstruct her social network, getting in contact with former friends and co-workers, and finding interesting leisure activities. This strategy proved successful as Angela started calling old friends and eventually arranged in-person contacts with them.

A session was dedicated to explaining to Angela the underlying factors that seemed to be contributing to the maintenance of her symptoms. As Angela was already familiar with CBT rationales and how cognitions about events affect behaviors (the initial sessions were dedicated to psychoeducation about CBT and OCD), all the points in Figure 1 were presented to Angela. It was clarified that the presence of her brother-in-law, the presence of physically attractive men, and her strong religious concepts seemed to trigger the belief that admiring another man's physical appearance was a betrayal and a sin. This was accompanied by emotions of anxiety, guilt, and distress. The cleaning rituals and avoiding her brother-in-law were behaviors that led to the lowering of anxiety and relief from guilt. She understood this formulation and agreed that it made sense.

Then, activities that favored the development of physical contact were incorporated into the treatment, such as progressive muscular relaxation (Jacobson, 1948), diaphragmatic breathing (Hawton et al., 1989), non-sexual affection exchange with her husband, and the suggestion of massage sessions (with a masseuse or physiotherapist) in order to make the client more aware of her body and to learn how to relax it. These suggestions were followed by Angela, with the exception of massage sessions. Although she liked massage and had tried it before, she did not want to invest money in it.

Concomitantly, sessions focused on cognitive restructuring (Beck, 1991; Blackburn & Twaddle, 1996), in order to initiate a change in fairly rigid cognitions ("I can't lower my guard with my husband," "I am going to be rejected by my husband if I show my affection spontaneously," "Sexual desire is sinful"). The possibility of couple therapy was rejected, as Angela and her husband had already tried it in the past unsuccessfully and due to her husband's resistance.

Other procedures employed included encouraging Angela to get in contact with fantasies relating to her brother-in-law. These were imagination/visualization activities, where Angela would close her eyes and imagine encounters of a sexual nature with her brother-in-law. She was asked to describe it in detail, giving information about the environment (location, weather, etc.),

Pragmatic Case Studies in Psychotherapy, http://pcsp.libraries.rutgers.edu
Volume 9, Module 1, Article 4, pp. 81-97, 02-17-13 [copyright by authors]

and physical sensations and emotions. Nevertheless, in order for such activities to be implemented in a way that would not increase the client's anguish, they were preceded and accompanied by discussions about her Catholic beliefs and cognitive restructuring exercises. Through Socratic questioning, I investigated why just admiring another man's appearance and having sensual/sexual thoughts was considered a sin, how the concept of sin has changed over time (i.e., what was considered a heresy in the past is not anymore), and how much control can anyone have over their thoughts. Angela came to the conclusion that the concept of sin is somewhat fluid, that it can change over time. She then considered that thinking about another man's attractiveness and even experiencing some desire might not be considered a sin. Also she agreed that she had very little control over her thoughts, but she was certain she would not act on those thoughts, as she respected her husband.

Equally important to Angela complying with these exercises was the therapeutic alliance, as it enabled Angela to feel confident, not judged, and at ease with me. Moreover, new psychoeducation sessions were introduced, such as teaching Angela to consider her obsessions as by-products of OCD instead of as real inclinations, to accept these thoughts in a non-judgmental manner, to stop trying to avoid them at all costs, and to view them as annoying but transient thoughts. Such a procedure has been reported as useful in the treatment of OCD (Gordon, 2002), and it helped Angela to comprehend the rationale involved in imagination/visualization activities and to facilitate her compliance with them.

Angela's initial objectives were to obtain a decrease in rituals and an improvement in anxiety. In this sense, the objectives were reached, albeit in a longer time-frame than expected by Angela and her psychiatrist. *After five months of therapy,* Angela was able to perform imagination exposures, without my being present, although inconsistently (i.e., only once or twice a week), and only for up to 20 minutes.

After seven months of therapy, Angela's anxiety levels were significantly lower when she had contact with her brother-in-law, and she was able to abandon the ritual of cleaning her husband's car; nevertheless, she still felt some disgust in having contact with him.

Furthermore, *after nine months of therapy*, Angela stopped changing her clothes when arriving home and could start doing exposure exercises by herself, although in an inconsistent fashion. At most, Angela performed them only two or three times a week, and there were times when several weeks passed without her practicing them at all.

The most substantial gains were obtained *after two years of therapy*. Angela reached a significantly lower level of anxiety, illustrated in the ceasing of her performing several rituals. She was able to open the elevator door in her apartment and press its buttons using her entire hand, sit anywhere at both the dining and kitchen tables, sit anywhere on the sofa, use the TV remote control, and hold her husband's mobile phone. She was able to do all these activities without the washing and cleaning rituals afterwards.

After three years of therapy Angela was able to express affection towards her husband without feeling "abused," and she had obtained substantial relief in the discomfort she felt with regard to her brother-in-law, even though it did not reduce completely. Nevertheless, she could

Pragmatic Case Studies in Psychotherapy, http://pcsp.libraries.rutgers.edu
Volume 9, Module 1, Article 4, pp. 81-97, 02-17-13 [copyright by authors]

visit him and his family, greet him with a hand shake, and even experience enjoyment in social events with them.

Additionally, as she attested, diaphragmatic breathing and progressive muscular relaxation were effective tools in helping her deal with anxiety symptoms, restoring feelings of empowerment and confidence that she was able to deal with some disturbing symptoms.

Throughout treatment, there was practically no modification in medication dosage, but in the last year of therapy the dose was gradually reduced and in the final three months of treatment Angela was using half the initial dosage (125mg/day of clomipramine). Angela and I agreed to end treatment after I pointed out that Angela already had all the necessary tools to deal with her anxiety, obsessions, and rituals and had obtained significant relief from her anxiety. Angela concurred and verbalized that further improvements depended on her own efforts, but that such an investment was too demanding, as OCD did not disturb her so much anymore.

It is important to highlight the strong therapeutic relationship that was developed with Angela over the course of therapy. The therapeutic relationship has been regarded as an important feature of many psychotherapeutic approaches (Garfield, 1995; Roth & Fonagy, 1996), including CBT (Beck, 1991; Gilbert & Leahy, 2007). Although it has been said that CBT may be less influenced by the quality of the therapeutic relationship (Roth & Fonagy, 1996), other studies indicate a stronger association between this relationship and outcome in CBT than in psychodynamic therapy (Stiles et al., 1998), and it has been argued that it has a stronger impact than technical factors on the course of CBT (Castonguay et al., 1996).

The therapeutic relationship was initially developed through my validation of Angela problems, with my taking an interested, normalizing, and non-judgmental posture. In the first session, I explained basic important components of psychotherapy (confidential and ethical aspects), clarified aspects of OCD symptoms and the rationale of CBT (i.e., psychoeducation), asked Angela what were her expectations of treatment, and gave Angela all her contact details (office and mobile phones, e-mail), presenting myself as a very accessible professional. This progressively evolved to Angela viewing me as a trust-worthy and knowledgeable person to whom she could disclose her most intimate worries, beliefs, and emotions. These were demonstrated by some of Angela verbalizations, such as "I like coming here because I always learn new things, " and "It is the one time in my week when I can talk about anything I want, my emotions, my worries, and fears." Additionally, I occasionally asked Angela for feedback on the treatment progress and checked what she still hoped to achieve in therapy. All these aspects seem to have contributed to the establishment of a positive and reinforcing relationship, which facilitated the guided discovery process inherent to CBT, and the client's willingness to re-assess dysfunctional beliefs.

Therapeutic relationships which are viewed as positive by clients can (a) motivate a client to progress through the exploration of empirical evidence rather than persuasion (Beck & Young, 1985), (b) provide a safe base from which a client can explore, (c) promote a client's hope, (d) disconfirm a client's dysfunctional beliefs, and (e) raise a client's self-awareness (Waddington, 2002).

Another important aspect of my therapeutic relationship with Angela is that even when I took a more confrontational approach, Angela views about the treatment were considered important and the guided-discovery process was stimulated, all by asking Angela what she thought could be keeping her from progressing. Asking clients their perspective on the treatment and providing them with a treatment rationale are also factors that maximize the therapeutic relationship (Waddington, 2002).

Angela was never pressured to show improvements (i.e., a specific, expected period of time for improvement was never provided), nor was she was pushed to perform homework. Instead, difficulties in performing homework were discussed, ideas of relevant homework assignments were shared with Angela, and she was even asked to assign herself homework she thought would be useful. That is, she was invited to take an active part in therapy and it was clarified that her collaboration, time, and energy investments were essential to treatment progress.

Newman (2007) argues that the therapeutic relationship does not have to be always smooth for CBT to be effective and that treatment cannot be rushed, as it risks a decrease in outcomes. The author also posits that some clients mistakenly believe that therapy's exclusive aim is to restore a sense of comfort and resist the notion that they need to invest effort to make changes or to learn skills to be able to make changes. This appears to have been, to some extent, the situation with Angela. She had already obtained gains with treatment and learned the necessary tools to obtain further improvement. Although extra progress could still be reached, she clearly stated that she was not willing to invest extra effort. Respecting the limits clients set is another important feature of a healthy therapeutic relationship (Newman, 2007).

7. THERAPY MONITORING AND USE OF FEEDBACK INFORMATION

The therapy was monitored by a careful, critical review of each session after it occurred, with resultant ideas about how to revise and guide the therapy course in terms of the overall therapeutic goals. The therapist, the first author, reviewed and discussed the progress of each session with the second author in peer-supervision.

8. CONCLUDING EVALUATION OF THE THERAPY'S PROCESS AND OUTCOME

Hayes et al. (1996) posit that the classifications proposed by DSM-IV-R and ICD-X are syndromic (i.e., they only describe the symptoms and signals experienced by the client topographically). While these classification systems ultimately aim to identify the etiology and course of disorders as well as treatment response, they cannot identify the underlying functional relationships which, according to the authors, are the most important consideration in decisions about treatment. The authors propose a classification for mental disorders, in which these underlying functional relationships are central, including the aspects that may have contributed to the emergence and maintenance of such behaviors. Although, as stated by the authors, such an approach would be less direct than that proposed by the traditional classification manuals, it

Pragmatic Case Studies in Psychotherapy, http://pcsp.libraries.rutgers.edu
Volume 9, Module 1, Article 4, pp. 81-97, 02-17-13 [copyright by authors]

seems to be in line to what is obtained through functional analysis, as this procedure clarifies the underlying functionality of symptoms.

Despite the fact that Angela did not achieve absolute relief from obsessions and rituals, we believe that the self-knowledge obtained in therapy was essential, as Angela became more aware of herself, acquired greater clarity about the processes that initiated and maintained her symptoms, and thus was more conscious about her choices and could make well-informed decisions, including deciding that she was unwilling to make the necessary investment to achieve a greater decrease in symptoms. According to Skinner (1974), anyone who obtains an improvement in self-knowledge is well-equipped to better predict and control their own behavior. Additionally, Gibbs (1996) has suggested that an absolute absence of obsessions might not be possible, as minor obsessions or compulsions can occur in people not diagnosed with OCD. Thus, being completely symptom-free should not be the only outcome measure to assess treatment efficacy, and a patient's overall functionality level should be taken into account (Abramowitz, 1998). Although a functional outcome measure was not used for assessment and, to our knowledge, such an instrument is not available in Portuguese, it is important to emphasize that Angela's functionality was not intensively affected by her symptoms. She clearly stated that obsessions and compulsions did not occupy much time in her day and no specific, major arrangement in her routine was necessary since her symptoms had started. Nevertheless, she felt it was important to seek therapy because this discomfort had been present for 20 years. As her OCD symptoms were sub-clinical, it was difficult to assess them through more objective measures that might not be sensitive enough to capture subtle changes.

As described above, the development of a solid therapeutic relationship with Angela greatly helped her to work towards greater self-knowledge, while being open to discuss her deeply rooted religious beliefs and to understand that these could be associated with her symptoms. CBT therapy is not a mere application of techniques. It involves a human relationship that can aid or prevent its effectiveness (Gilbert & Leahy, 2007; p. xi). The therapeutic relationship/alliance has been repeatedly reported as an important factor in the treatment of OCD, and its quality predicts positive results from cognitive-behavioral treatments (Keijsers et al., 1994; Vogel et al., 2006; Keeley et al., 2008), whereas treatment expectancy and motivation do not seem to predict positive outcomes (Vogel et al., 2006). Literature indicates that the development of a positive therapeutic relationship requires a longer period of treatment, without a defined protocol or quantities of pre-programmed sessions, and may take up to three years (Kohlenberg & Vandenbergue, 2007). Clinical trials and review studies have also posed the issue that more sessions than proposed by manuals might be necessary for improvement (Simpson et al., 2008; Keeley et al., 2008).

In this context, it is important to point out that after the first year, in spite of therapy focusing on an analysis of Angela's poor compliance, Angela remained committed to the amelioration of her initial presenting issues, such as the repulsion she felt towards her brother-in-law and the generalization of her symptoms to everything he might have touched. Specifically, Angela achieved gains on these issues in the second and third years of therapy. In other words, from this point forward, the therapeutic relationship took on a more central role than the CBT techniques and yet therapy remained effective.

Pragmatic Case Studies in Psychotherapy, http://pcsp.libraries.rutgers.edu
Volume 9, Module 1, Article 4, pp. 81-97, 02-17-13 [copyright by authors]

Taking into consideration that manual-oriented OCD treatments seldom have more than a 50% success rate (Keijsers et al., 1994; Whittal &McLean, 1999) when drop-out and refusal for treatment rates are considered, and up to 71% of patients do not reach a reduction in symptoms (Simpson et al., 2006; Simpson et al., 2008), this report supports those cognitive-behavioral therapists who are also critics of a "one size fits all" approach, like Zamignani and Andery (2005). Manual-driven treatments possibly do not allow the development of the therapeutic relationship in a way that can expand the benefits of cognitive-behavioral techniques which, when applied solely and in a "one size fits all" manner, lead to restricted gains.

Treatment manuals are of paramount importance, as they provide sound procedures on which professionals can safely rely for targeting specific symptoms. This also proves beneficial for young practitioners, who feel secure in following standardized techniques. Manuals also facilitate treatment replication, which is vital for research development. Nevertheless, each client is unique and one procedure that has been described as effective for many clients might prove otherwise to any specific patient. In this sense, manuals should not be used as "recipes" to be followed strictly and rigidly. The careful functional analysis and the development of a solid therapeutic relationship are crucial to the management of difficulties presented by each client and a positive treatment response. These factors rely on the professional clinical assessment and judgment and might take more time than a set number of sessions. Thus, a flexible posture seems to be beneficial to cognitive-behavioral therapists. As stated by Newman (2007), cognitive behavioral therapists have to be flexible in the application of the model and techniques and adapt the treatment to the needs and capabilities of a certain client at specific times.

A main limitation of this case study is that the reduction in medication dosage, the client's un-standardized report, and the therapist's un-standardized observations are the only sources of information about the results obtained. Not only that, clients who present sub-clinical symptoms pose another challenge: enabling an objective assessment measure. Although standardized measures should be part of CBT conducted in a naturalistic setting, such an evaluation might be daunting as subtler (but still important changes) may not be adequately identified by such instruments. In fact, currently available assessment instruments for OCD have been reported to lack sensitivity to treatment change across all types of treatments, the nature, and associated impairment of specific symptoms (Grabill et al., 2008). The Y-BOCS is the most widely used symptom checklist for OCD, but many limitations have been reported, such as under-representations of particular, rarer or less studied symptoms and lack of identification of the functional relationship between obsessions and compulsions (Conelea, Freeman, Garcia, 2012).

Although this case study lacks results from a standardized objective measure at post-treatment (i.e. Y-BOCS), the reduction in medication to half the initial dosage should be considered as a sign of objective positive results. Considering the patient was taking clomipramine for the previous eight years before commencing CBT, there is a high probability that maximum medication effects were present before the beginning of psychotherapy, thus, reduction in medication dosage could be attributed to the efficacy of therapy.

Nevertheless, we believe that the practical and theoretical aspects illustrated pose questions that need to be addressed and further investigated within CBT for OCD, considering

the difficulties in completely eliminating the symptoms of this disorder. Clinical trials are of utmost significance to investigating aspects of OCD in large samples, but case studies can shed light in smaller but important aspects of individual treatment and thus their relevance should not be diminished. Finally, case reports allow the description and analysis of detailed information that would be lost in larger quantitative, group studies, and in fact, naturalistic case studies represent the actual reality of the majority of therapists who work in private practice.

9. REFERENCES

Abramowitz, J.S. (1998). Does cognitive-behavioral therapy cure obsessive compulsive disorder? A meta-analytic evaluation of clinical significance. *Behavior Therapy, 29*, 339-55.

Abramowitz, J.S., Franklin, M.E., & Foa, E.B. (2002). Empirical status of cognitive-behavioral therapy for obsessive-compulsive disorder: a meta-analytic review. *Romanian Journal of Cognitive and Behavioral Psychotherapies, 2*, 89-104.

Abramowitz, J.S., Schwartz, S.A., Franklin, M.E., & Furr, J.M. (2003). Symptom presentation and outcome of cognitive-behavioral therapy for obsessive-compulsive disorder. *Joural of Consulting & Clinical Psychology, 71*, 1049-57.

Aksaray, G., Yelken, B., Kaptanoglu, C., Oflu, S., & Ozaltin, M. (2001). Sexuality in women with obsessive compulsive disorder. *Journal of Sex & Marital Therapy, 27*, 273-33.

American Psychiatric Association (2000). *Diagnostic and Statistical Manual of Mental Disorders*. 4.ed. text rev. Washington: APA.

Beck, A. (1991). *Cognitive therapy and the emotional disorders*. New York: Penguin.

Beck, A., & Young, J. (1985). Depression. In: D. Barlow D (ed). *Clinical handbook of psychological disorders.* New York: Guildord Press.

Blackburn, I.M., & Twaddle, V. (1996). *Cognitive therapy in action: A practitioner's casebook.* London: Souvenir Press Ltd.

Caballo, V.E. (1996) *Manual de Tecnicas de Terapia e Modificaco do Comportamento*. Sao Paulo: Santos.

Castonguay, C., Goldfried, M., Wiser, S., Raue, P., & Hayes, J. (1996). Predicting the effect of cognitive therapy for depression: a study of unique and common factors. *Journal of Consulting & Clinical Psychology, 67*, 578-82.

Cottraux, J., Note, I., Yao, S.N., Lafont, S., Note, B., Mollard, E., & Dartigues, J.F. (2001). A randomized controlled trial of cognitive therapy versus intensive behavior therapy in obsessive compulsive disorder. *Psychotherapy and Psychosomatics, 70*, 288-97.

Conelea, C.A., Freeman, J.B., & Garcia, A.M. (2012). Integrating behavioral theory with OCD assessment using the Y-BOCS/CY-BOCS symptom checklist. *Journal of Obsessive-Compulsive and Related Disorders, 1*, 112-18.

Eichsted, J.A., & Arnold, S.L. (2001). Childhood-onset obsessive-compulsive disorder: A tic-related subtype of OCD? *Clinical Psychological Review, 21*, 137-58.

Eisen, J.L., Goodman, M.B., & Keller, M.B. (1999). Patterns of remission and relapse in obsessive-compulsive disorder: A 2-year prospective study. *Journal of Clinical Psychiatry, 60*, 346-51.

Emmelkamp, P.M.G., Vedel, E., & Kamphuis, J.H. (2007). Behaviour therapy. In: C. Freeman & M. Power (Eds.). *Handbook of evidence-based psychotherapies: A guide for research and practice* (pp. 61-81). West Sussex: John Wiley & Sons.

Emmelkamp, P.M.G., Visser, S., & Hoekstra, R. (*1988).* Cognitive therapy vs. exposure in the treatment of obsessive-compulsives. *Cognitive Therapy and Research, 12*, 103-14.

Ferrão, Y.A., Shavitt, R.G., Bedin, N.R., Mathis, M.E., Lopes, A.C., Fontenelle, L.F., et al. (2006). Clinical features associated with refractory obsessive-compulsive disorder. *Journal of Affective Disorders, 94*, 199-209.

Garfield, S.L.(1995). *Psychotherapy: An eclectic-integrative approach.* USA: John Wiley & Sons.

Gaudiano, B.A. (2008). Cognitive-behavioral therapies: achievements and challenges. *Evidence-Based Mental Health, 1,* 5-7.

Gibbs, N.A. (1996). Non clinical populations in research on obsessive-compulsive disorder: A critical review. *Clinical Psychology Review, 16*, 729-73.

Gilbert, P., & Leahy, R.L. (2007). Preface. In: P. Gilbert & R.L. Leahy (Eds.). *The therapeutic relationship in the cognitive behavioral psychotherapies*. East Sussex: Routledge.

Goodman, W.K., Price, L.H., Rasmussen, S.A., Mazure, C., Fleischmann, R.L., Hill, C.L, et al. (1989) The Yale-Brown Obsessive Compulsive Scale (Y-BOCS): Development, use and reliability. *Archives of General Psychiatry*, *46*, 1006-11.

Gordon, W.M. (2002). Sexual obsessions and OCD. *Sexual and Relationship Therapy*, *17*, 343-354.

Grabill, K., Merlo, L., Duke, D., Harford, K.L., Keeley, M.L., Geffken, G.R., & Storch, E.A. (2008). Assessment of obsessive compulsive disorder: A review. *Journal of Anxiety Disorders, 22,* 1-17.

Hall, K., & Iqbal, F. (2010). *The problem with cognitive behavioural therapy*. London: Karnac Books.

Hayes, S.C., Wilson, K.G., Gifford, E.V., Follette, V.M., & Strosahl, K. (1996). Experiential avoidance and behavioral disorders: A functional dimensional approach to diagnosis and treatment. *Journal of Consulting and Clinical Psychology, 64*, 1152-68.

Haynes, S.N., O'Brien, W.H. (1990). Functional analysis in behavior therapy. *Clinical Psychology Review, 10*, 649-68.

Hawton, K., Salkoviskis, P.M., Kirk, J., & Clark, D.M. (Eds.). (1989). *Cognitive behaviour therapy for psychiatric problems: A practical guide*. Oxford: Oxford University Press.

Jacobson, E. (1948). *Progressive Relaxation: A physiological and clinical investigation of muscular states and their significance in psychology and medical practice*. Chicago: The University of Chicago Press.

Keeley, M.L., Storch, E.A., Merlo, L.J., & Geffken, G.R. (2008). Clinical predictor of response to cognitive-behavioral therapy for obsessive-compulsive disorder. *Clinical Psychology Review, 28,*118-30.

Keijsers, G.P.J., Hoogduin, C.A.L., & Schaap, C.P.D.R. (1994). Predictors of treatment outcome in the behavioural treatment of obsessive-compulsive disorder. *British Journal of Psychiatry, 165*, 781-86.

Kohlenberg, R.J., & Vandenbergue, L. (2007). Treatment-resistance OCD, inflated responsibility and the therapeutic relationship: Two case examples. *Psychology and Psychotherapy: Theory, Research and Practice, 80*, 455-65.

Lindsay, M., Crino, R, & Andrews, G. (1997). Controlled trial of exposure and response prevention in obsessive-compulsive disorder. *British Journal of Psychiatry, 171*, 135-39.

March, J.S., Frances, A., Carpenter, D., & Kahn, D. (1997). The expert consensus guideline series: Treatment of obsessive-compulsive disorder. *Journal of Clinical Psychiatry*, Sup *58*, 11-14.

Mataix-Cols, D., Rosario-Campos, M.C., & Leckman, J.F. (2005). A multidimensional model of obsessive-compulsive disorder. *American Journal of Psychiatry, 162*, 228-38.

Milton, J. (2001). Psychoanalysis and cognitive behaviour therapy–rival paradigms or common ground? *International Journal of Psychoanalysis, 82*, 431-47.

Newman, C.F. (2007). The therapeutic relationship in cognitive therapy with difficult-to-engage clients. In: P. Gilbert & R.L. Leahy (Eds.). *The therapeutic relationship in the cognitive behavioral psychotherapies*. East Sussex: Routledge.

Roth, A., & Fonagy, P. (1996). *What works for whom? A critical review of psychotherapy research.* London: Guilford Press.

Simpson, H.B., Huppert, J.D., Petkova, E., Foa, E.B., & Liebowitz, M.R. (2006). Response versus remission in obsessive compulsive disorder. *Journal of Clinical Psychiatry, 67*, 269-76.

Simpson, H.B., Foa, E.B., Liebowitz, M.R., Ledley, D.R., Huppert, J.D., Cahill, S. et al. (2008). A randomized, controlled trial of cognitive-behavioral therapy for augmenting pharmacotherapy in obsessive-compulsive disorder. *American Journal of Psychiatry, 165*, 621-30.

Skinner, B.F. (1974). *About behaviorism*. New York: Vintage Books.

Stiles, W.B., Agnew-Davies, R., Hardy, G., Barkham, M., & Shapiro, D.A. (1998). Relations of the alliance with psychotherapy outcome: findings in the second Sheffield Psychotherapy Project. *Journal of Consulting aznd Clinical Psychology, 66*, 791-902.

Stein, D.J. (2002). Obsessive-compulsive disorder. *Lancet, 360*, 397-405.

Van Balkom, A.J.L.M., Van Oppen, P., Vermeulen, A.W.A., Van Dyck, R., Nauta, M.C.E., & Vorst, H.C.M. (1994). A meta-analysis on the treatment of obsessive compulsive disorder: a comparison of antidepressants, behavior and cognitive therapy. *Clinical Psychology Review, 14*, 359-81.

Van Oppen, P., Haan, E.D., Van Balkon, A.J.L.M., Spinhoven, P., Hoogduin, K., & Van Dick, R. (1995). Cognitive therapy and exposure in vivo in the treatment of obsessive-compulsive disorder. *Behaviour Research and Therapy, 33*, 379-90.

Vogel, P.A., Hansen, B., Stiles, T.C., & Gotestam, K.G. (2006). Treatment motivation, treatment expectancy, and helping alliance as predictors of outcome in cognitive behavioral treatment of OCD. *Journal of Behavior Therapy and Experimental Psychiatry, 37*, 247-55.

Zamignani, D.R.,& Andery, M.A.P.A. (2005). Interaction between behavior therapists and their clients diagnosed with obsessive-compulsive disorder. *Psicologia: teoria e pesquisa, 21*, 109-19.

Waddington, L. (2002). The therapy relationship in cognitive therapy: a review. *Behavioural and Cognitive Psychotherapy, 30*, 179-91.

Whittal, M.L., & McLean, P.D. (1999). CBT for OCD: Rationale, protocol and challenges. *Cognitive and Behavioral Practice, 6*, 383-96.

World Health Organization. (1990). International Statistical Classification of Diseases and Related Health Problems. 10.ed. New York: WHO.

Figure 1: Functional Analysis Diagram